



RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS Clinical Reporting System

(BGP)

Selected Measures (Local) Report Performance Measure List and Definitions

Version 16.1
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1.0 CRS Selected Measures (Local) Report

The performance measure topics and their definitions that are included in the Clinical Reporting System (CRS) 2016 version 16.1 Selected Measures (Local) Reports are shown in Section 2.0. Performance measures that are also included in the National Government Performance and Results Act of 1993 (GPRA)/GPRA Modernization Act (GPRAMA) Report are shown in Section 1.1.

Many performance measure topics include both the Active Clinical and User Population denominators. For brevity, the User Population denominator is not listed separately. To see which topics include the User Population denominator, refer to the *CRS Clinical Performance Measure Logic Manual for FY 2016 Clinical Measures*.

1.1 Performance Measures Included in the CRS 2016 National GPRA/GPRAMA Report

The following performance measures are reported in the CRS 2016 National GPRA/GPRAMA Report.

Notations used in this document are described in Table 1-1.

Table 1-1: Document Notations

Notation	Location	Meaning
GPRA:	Preceding a measure	An official GPRA measure reported in the National GPRA Report submitted to the Office of Management and Budget (OMB) and Congress in the annual IHS budget process.
GPRAMA:	Preceding a measure	An official GPRAMA measure reported in the National GPRA Report submitted to the Office of Management and Budget (OMB) and Congress, and included in the annual HHS Online Performance Appendix.
Plus Sign (+)	Preceding a measure	The measure is <i>not</i> an official GPRA measure but <i>is included</i> in the National GPRA Report provided to OMB and Congress to provide context to a GPRA measure.
Section Symbol (§)	Preceding a measure	The measure is <i>not</i> an official GPRA measure and <i>is not included</i> in the National GPRA Report provided to OMB and Congress. Included in this document to provide context to a GPRA measure.

Notation	Location	Meaning
Asterisk (*)	Anywhere in a code	A <i>wildcard</i> character indicating that the code given has one or more additional characters at this location.

DIABETES GROUP

- DIABETES PREVALENCE
 - +Diabetes Diagnosis Ever
 - §Diabetes Diagnosis during GPRA Year
- GLYCEMIC CONTROL
 - +Documented Alc
 - Poor Glycemic Control
 - §A1c greater than or equal to (\geq)7 and less than ($<$) 8
 - GPRAMA: Good Glycemic Control
 - A1c less than ($<$) 7
- BLOOD PRESSURE CONTROL
 - §Blood Pressure (BP) Assessed
 - GPRA: Controlled BP (less than ($<$) 140/90)
- STATIN THERAPY TO REDUCE CARDIOVASCULAR DISEASE RISK IN PATIENTS WITH DIABETES
 - GPRA: With Statin Therapy
 - §With Denominator Exclusions
- NEPHROPATHY ASSESSMENT
 - GPRA: Estimated Glomerular Filtration Rate (GFR) & Urine Albumin-to-Creatinine Ratio (UACR) or History of End Stage Renal Disease (ESRD)
- RETINOPATHY ASSESSMENT
 - GPRA: Retinopathy Evaluation (No Refusals)

DENTAL GROUP

- ACCESS TO DENTAL
 - GPRA: Annual Dental Visit (No Refusals)
- DENTAL SEALANTS
 - GPRA: Dental Sealants (rate)
 - §Dental Sealants (No Refusals; count; not rate)

- TOPICAL FLUORIDE
 - GPRA: Topical Fluoride (rate)
 - §Topical Fluoride Application (No Refusals; count; not rate)

IMMUNIZATIONS

- INFLUENZA
 - GPRA: Influenza Immunization 6 months – 17 years
 - GPRA: Influenza Immunization 18 years and older
- ADULT IMMUNIZATIONS
 - GPRA: Pneumococcal
- CHILDHOOD IMMUNIZATIONS (19 THROUGH 35 MONTHS)
 - §Active Clinical Patients with 4:3:1:3*:3:1:4 (No Refusals)
 - GPRAMA: Active IMM Patients with 4:3:1:3*:3:1:4 (No Refusals)
 - §four DTaP
 - §three Polio
 - §one MMR
 - §three or four HiB
 - §three Hepatitis B
 - §one Varicella
 - §four Pneumococcal

CANCER SCREENING

- PAP SMEAR RATES
 - GPRA: Pap smear in past 3 years or for age 30+, Pap & HPV in past 5 years (No Refusals)
- MAMMOGRAM RATES
 - GPRA: Mammogram (No Refusals)
- COLORECTAL CANCER SCREENING
 - GPRA: Fecal Occult Blood Test (FOBT) or Fecal Immunochemical Test (FIT) during Report Period, Flexible Sigmoidoscopy in past 5 years, or Colonoscopy in past ten years (No Refusals)
 - §FOBT or FIT

- TOBACCO USE AND EXPOSURE ASSESSMENT
 - §Tobacco Assessment
- §Tobacco Users
 - §Smokers
 - §Smokeless Users
- §Exposed to Environmental Tobacco Smoke (ETS)
- TOBACCO CESSATION
 - §Tobacco Cessation Counseling or Smoking Cessation Aid (No Refusals)
 - §Quit Tobacco Use
 - GPRA: Tobacco Cessation Counseling, Smoking Cessation Aid, or Quit Tobacco Use

BEHAVIORAL HEALTH

- ALCOHOL SCREENING (FETAL ALCOHOL SYNDROME [FAS] PREVENTION)
 - GPRA: Alcohol Screening (No Refusals)
 - §Positive Alcohol Screen
- INTIMATE PARTNER VIOLENCE/DOMESTIC VIOLENCE (IPV/DV) SCREENING
 - GPRA: IPV/DV Screening (No Refusals)
- DEPRESSION SCREENING
 - GPRAMA: Depression Screening or Mood Disorder Diagnosis (No Refusals)
 - §Depression Screening
 - §Mood Disorder Diagnosis

CARDIOVASCULAR DISEASE-RELATED

- CHILDHOOD WEIGHT CONTROL
 - GPRA: BMI 95% and Up
- CONTROLLING HIGH BLOOD PRESSURE – MILLION HEARTS
 - GPRA: BP less than (<) 140/90
- COMPREHENSIVE CVD-RELATED ASSESSMENT
 - GPRAMA: BP and Tobacco Assessed, BMI, and Lifestyle Counseling (No Refusals)
 - §Depression Screen

STD GROUP

- HIV SCREENING
 - §Prenatal HIV Screening (No Refusals)
 - GPRA: HIV Screen Ever (No Refusals)

OTHER CLINICAL

- BREASTFEEDING RATES
 - Patients 30 through 394 days of age screened for infant feeding choice (IFC) at least once
 - Patients 30 through 394 days of age screened for IFC at the age of 2 months
 - Patients 30 through 394 days of age screened for IFC at the age of 6 months
 - Patients 30 through 394 days of age screened for IFC at the age of 9 months
 - Patients 30 through 394 days of age screened for IFC at the age of 1 year
 - GPRA: Patients 30 through 394 days of age who were exclusively or mostly breastfed at 2 months of age
 - Patients 30 through 394 days of age who were exclusively or mostly breastfed at 6 months of age
 - Patients 30 through 394 days of age who were exclusively or mostly breastfed at 9 months of age
 - Patients 30 through 394 days of age who were exclusively or mostly breastfed at the age of 1 year

Note: Definitions for all performance measure topics included in CRS begin on Section 2.0. Definitions for numerators and denominators that are preceded by “GPRA” represent measures that are reported to OMB and Congress.

1.2 CRS Denominator Definitions

1.2.1 For All Denominators

- All patients with name “DEMO, PATIENT” or who are included in the RPMS Demo/Test Patient Search Template (DPST option located in the Patient Care Component (PCC) Management Reports, Other section) will be excluded automatically for all denominators.

- For all measures except as noted, patient age is calculated as of the beginning of the Report Period.

1.2.2 Active Clinical Population

1.2.2.1 National GPRA/GPRAMA Reporting

- Must have two visits to medical clinics in the past three years. Chart reviews and telephone calls from these clinics do not count; the visits must be face-to-face. At least one visit must be to a core medical clinic. Refer to the *Clinical Reporting System (CRS) for FY2016 Clinical Measures User Manual* for a listing of these clinics.
- Must be alive on the last day of the Report Period.
- Must be American Indian/Alaska Native (AI/AN); defined as Beneficiary 01.
- Must reside in a community specified in the site's GPRA community taxonomy, defined as all communities of residence in the defined Purchased and Referred Care (PRC) catchment area.

1.2.2.2 Local Reports

- Must have two visits to medical clinics in the past three years. Chart reviews and telephone calls from these clinics do not count; the visits must be face-to-face. At least one visit must be to a core medical clinic. Refer to the *CRS for FY2016 Clinical Measures User Manual* for a listing of these clinics.
- Must be alive on the last day of the Report Period.
- User defines population type: AI/AN patients only, non-AI/AN, or both.
- User defines general population: single community, group of multiple communities (community taxonomy), user-defined list of patients (patient panel), or all patients regardless of community of residence.

1.2.3 User Population

1.2.3.1 National GPRA/GPRAMA Reporting

- Must have been seen at least once in the three years prior to the end of the time period, regardless of the clinic type, and the visit must be either ambulatory (including day surgery or observation) or a hospitalization; the rest of the service categories are excluded.
- Must be alive on the last day of the Report Period.

- Must be AI/AN; defined as Beneficiary 01.
- Must reside in a community specified in the site's GPRC community taxonomy, defined as all communities of residence in the defined PRC catchment area.

1.2.3.2 Local Reports

- Must have been seen at least once in the three years prior to the end of the time period, regardless of the clinic type, and the visit must be either ambulatory (including day surgery or observation) or a hospitalization; the rest of the service categories are excluded.
- Must be alive on the last day of the Report Period.
- User defines population type: AI/AN patients only, non-AI/AN, or both.
- User defines general population: single community, group of multiple communities (community taxonomy), user-defined list of patients (patient panel), or all patients regardless of community of residence.

1.2.4 Active Clinical Plus BH Population

1.2.4.1 National GPRC/GPRAMA Reporting

- Must have two visits to medical clinics in the past three years. Chart reviews and telephone calls from these clinics do not count; the visits must be face-to-face. At least one visit must be to a core medical clinic. Refer to the *Clinical Reporting System (CRS) for FY2016 Clinical Measures User Manual* for a listing of these clinics.
- Must be alive on the last day of the Report Period.
- Must be AI/AN; defined as Beneficiary 01.
- Must reside in a community specified in the site's GPRC community taxonomy, defined as all communities of residence in the defined PRC catchment area.

1.2.4.2 Local Reports

- Must have two visits to medical clinics in the past three years. Chart reviews and telephone calls from these clinics do not count; the visits must be face-to-face. At least one visit must be to a core medical clinic. Refer to the *Clinical Reporting System (CRS) for FY2016 Clinical Measures User Manual* for a listing of these clinics.
- Must be alive on the last day of the Report Period.
- User defines population type: AI/AN patients only, non AI/AN, or both.

- User defines general population: single community, group of multiple communities (community taxonomy), user-defined list of patients (patient panel), or all patients regardless of community of residence.

2.0 Performance Measure Topics and Definitions

The following sections define the performance measure topics and their definitions that are included in the CRS 2016 version 16.1 Selected Measures (Local) Report.

2.1 Diabetes Group

2.1.1 Diabetes Prevalence

2.1.1.1 Owner and Contact

Diabetes Program: Dr. Ann Bullock

2.1.1.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; *not* reported to OMB and Congress)

2.1.1.3 Denominators

1. User Population patients.

2.1.1.4 Numerators

1. Patients diagnosed with diabetes ever.
2. Patients diagnosed with diabetes during the Report Period.

2.1.1.5 Definitions

Diabetes Diagnosis

Diabetes diagnosis is defined as at least one Purpose of Visit [POV] diagnosis ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.*.

2.1.1.6 Patient List

List of diabetic patients with most recent diagnosis.

2.1.2 Diabetes: Comprehensive Care

2.1.2.1 Owner and Contact

Diabetes Program: Dr. Ann Bullock

2.1.2.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; not reported to OMB and Congress)

2.1.2.3 Denominators

1. Active Diabetic patients, defined as Active Clinical patients diagnosed with diabetes prior to the Report Period, *and* at least two visits in the past year, *and* two Diabetes Mellitus (DM)-related visits ever.
2. Active Diabetic patients, defined as Active Clinical patients diagnosed with diabetes prior to the Report Period, **AND** at least two visits during the Report Period, **AND** two DM-related visits ever, without a documented history of bilateral blindness.
3. Active Diabetic patients, defined as Active Clinical patients diagnosed with diabetes prior to the Report Period, *and* at least two visits during the Report Period, *and* two DM-related visits ever, without a documented history of bilateral foot amputation or two separate unilateral foot amputations.

2.1.2.4 Numerators

1. Patients with hemoglobin A1c documented during the Report Period, regardless of result.
2. Patients with blood pressure documented during the Report Period
3. Patients with controlled blood pressure during the Report Period, defined as less than 140/90. This measure is not included in the comprehensive measure (Numerator 8)
4. Patients with LDL completed during the Report Period, regardless of result.
5. Patients with nephropathy assessment, defined as an estimated Glomerular Filtration Rate (GFR) with result *and* a Urine Albumin-to-Creatinine Ratio (UACR) during the Report Period *or* with evidence of diagnosis or treatment of end-stage renal disease (ESRD) at any time before the end of the Report Period.
6. Patients receiving a qualified retinal evaluation during the Report Period.

Note: This numerator does *not* include refusals.

7. Patients with diabetic foot exam during the Report Period.

Note: This numerator does *not* include refusals.

8. Patients with A1c *and* blood pressure assessed *and* nephropathy assessment *and* retinal exam *and* diabetic foot exam.

Note: This numerator does *not* include controlled blood pressure, only blood pressure assessment.

2.1.2.5 Definitions

Diabetes

First POV ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.* recorded in the V POV file prior to the Report Period.

A1c

Searches for most recent A1c test with a result during the Report Period. If none found, CRS searches for the most recent A1c test without a result.

A1c defined as:

- Current Procedural Terminology (CPT) 83036, 83037, 3044F through 3046F, 3047F (old code)
- Logical Observations Identifiers, Names, Codes (LOINC) taxonomy
- Site-populated taxonomy DM AUDIT HGB A1C TAX

BP Documented

Exclusions: When calculating all BPs (using vital measurements or CPT codes), the following visits will be excluded:

- Service Category H (Hospitalization), I (In Hospital), S (Day Surgery), or O (Observation)
- Clinic code 23 (Surgical), 30 (ER), 44 (Day Surgery), C1 (Neurosurgery), or D4 (Anesthesiology)

CRS uses the mean of the last three BPs documented during the Report Period. If three BPs are not available, it uses the mean of last two BPs, or one BP if there is only one documented. If a visit contains more than one BP, the lowest BP will be used, defined as having the lowest systolic value. The mean Systolic value is calculated by adding the last three (or two) systolic values and dividing by three (or two). The mean Diastolic value is calculated by adding the diastolic values from the last three (or two) blood pressures and dividing by three (or two).

If CRS is not able to calculate a mean BP, it will search for CPT 0001F, 2000F, 3074F through 3080F, G9273, G9274 or POV ICD-9: V81.1 documented during the Report Period.

Controlled BP

CRS uses a mean, as described previously. If the mean systolic and diastolic values do not *both* meet the criteria for controlled, then the value is considered not controlled.

BP Documented and Controlled BP

If CRS is not able to calculate a mean BP from blood pressure measurements, it will search for the most recent of any of the following codes documented during the Report Period:

- BP Documented: CPT 0001F, CPT 2000F, G9273, G9274, or POV ICD-9: V81.1; OR
- Systolic: CPT 3074F, 3075F, or 3077F with Diastolic: CPT 3078F, 3079F, or 3080F. The systolic and diastolic values do *not* have to be recorded on the same day. If there are multiple values on the same day, the CPT indicating the lowest value will be used.
- The following combinations represent BP less than 140/90 and will be included in the Controlled BP numerator: CPT 3074F or 3075F *and* 3078F or 3079F, OR G9273. All other combinations will *not* be included in the Controlled BP numerator.

Nephropathy Assessment

Defined as any of the following:

- Estimated GFR with result during the Report Period, defined as any of the following:
 - Site-populated taxonomy BGP GPRA ESTIMATED GFR TAX
 - LOINC taxonomy
- Urine Albumin-to-Creatinine Ratio during the Report Period, defined as any of the following:
 - CPT 82043 WITH 82570
 - LOINC taxonomy
 - Site-populated taxonomy BGP QUANT UACR TESTS

Note: Be sure to check with your laboratory supervisor that the names added to your taxonomy reflect quantitative test values.

- End Stage Renal Disease diagnosis or treatment defined as any of the following ever:
 - CPT 36145 (old code), 36147, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831 through 36833, 50300, 50320, 50340, 50360, 50365,

- 50370, 50380, 90951 through 90970 or old codes 90918 through 90925, 90935, 90937, 90939 (old code), 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512, 3066F, G0257, G0308 through G0327 (old codes), G0392 (old code), G0393 (old code), G9231, S2065, S9339
- POV ICD-9: 585.6, V42.0, V45.1 (old code), V45.11, V45.12, V56.*; ICD-10: N18.6, Z48.22, Z49.*, Z91.15, Z94.0, Z99.2
 - International Classification of Diseases (ICD) Procedure ICD-9: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93 through 39.95, 54.98, 55.6*

Qualified Retinal Evaluation

Either of the following:

- Diabetic retinal exam
- Other eye exam

The following methods are qualifying for this measure:

- Dilated retinal evaluation by an optometrist or ophthalmologist.
- Seven standard fields stereoscopic photos (Early Treatment Diabetic Retinopathy Study [ETDRS]) evaluated by an optometrist or ophthalmologist.
- Any photographic method formally validated¹ to 7 standard fields (ETDRS).

Diabetic Retinal Exam

Any of the following during the Report Period:

- Exam code 03 Diabetic Eye Exam (dilated retinal examination or formally validated² ETDRS photographic equivalent).
- CPT 2022F Dilated retinal eye exam, 2024F Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist, 2026F Eye imaging formally validated³ to match the diagnosis from 7 standard field stereoscopic photos, S0620 Routine ophthalmological examination including refraction; new patient, S0621 Routine ophthalmological examination including refraction; established patient, S3000 Diabetic indicator; retinal eye exam, dilated, bilateral.

¹ Validation study properly powered and controlled against the ETDRS gold standard (American Telemedicine Association validation category 3).

² Ibid.

³ Ibid.

Other Eye Exam

Any of the following during the Report Period:

- Non-DNKA (did not keep appointment) visits to ophthalmology or optometry clinics with an optometrist or ophthalmologist, or visits to formally validated⁴ teleophthalmology retinal evaluation clinics. Searches for the following codes in the following order:
 - CPT 67028, 67038 (old code), 67039, 67040, 92002, 92004, 92012, 92014
 - Clinic code A2 (Diabetic Retinopathy)⁵
 - Clinic codes 17⁶ or 18⁷ with Provider code 08, 24, or 79 where the Service Category is not C (Chart Review) or T (Telecommunications)

Bilateral Blindness

- Diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 369.01, 369.03, 369.04; ICD-10: H54.0 through H54.12

Diabetic Foot Exam

Any of the following:

- Exam code 28 Diabetic Foot Exam, Complete
- Non-DNKA visit with a podiatrist (Provider codes 33, 84, 25)
- Non-DNKA visit to Podiatry Clinic or Diabetic Foot Clinic (Clinic codes 65 and B7)
- CPT 2028F, G9226

Bilateral foot amputation

- CPT 27290.50 through 27295.50, 27590.50 through 27592.50, 27598.50, 27880.50 through 27882.50 (50 modifier indicates bilateral), G9224
- Procedure ICD-10: 0Y640ZZ

Unilateral foot amputation

- Must have two separate occurrences on two different dates of service:
 - CPT 27290 through 27295, 27590 through 27592, 27598, 27880 through 27882

⁴ Validation study properly powered and controlled against the ETDRS gold standard (American Telemedicine Association validation category 3).

⁵ Validated photographic (teleretinal) retinal surveillance (American Telemedicine Association validation category 3).

⁶ Ophthalmology or Optometry clinic codes (17, 18) cannot be used for non-qualifying photographic DR examination methods² unless a dilated retinal examination by an ophthalmologist or optometrist is also accomplished during the same encounter.

⁷ Ibid.

- Procedure ICD-9: 84.10, 84.13 through 84.19; ICD-10: 0Y6*0ZZ, 0Y6C0Z*, 0Y6D0Z*, 0Y6H0Z*, 0Y6J0Z*, 0Y6M0Z0, 0Y6N0Z0
- POV ICD-9: V49.7*

2.1.2.6 Patient List

Diabetic patients with documented tests, if any.

2.1.3 Diabetes: Glycemic Control

2.1.3.1 Owner and Contact

Diabetes Program: Dr. Ann Bullock

2.1.3.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.1.3.3 Denominators

1. User Population patients diagnosed with diabetes prior to the Report Period.
2. GPRAMA: Active Diabetic patients; defined as Active Clinical patients diagnosed with diabetes prior to the Report Period, *and* at two visits in the past year, *and* two DM-related visits ever. Key denominator for this and all diabetes-related topics that follow.
3. Active Adult Diabetic patients, defined by meeting the following criteria:
 - Who are 19 and older at the beginning of the Report Period
 - Whose first ever DM diagnosis occurred prior to the Report Period
 - Who had at least two DM related visits ever
 - With at least one encounter with DM POV in a primary clinic with a primary provider during the Report Period
 - Never have had a creatinine value greater than (>) 5

2.1.3.4 Numerators

1. Hemoglobin A1c documented during the Report Period, *regardless of result*.
2. Poor control: A1c greater than (>) 9.5.

3. Very poor control: A1c greater than or equal to (\geq) 12.
4. Poor control: A1c greater than ($>$) 9.5 and less than ($<$) 12.
5. Fair control A1c is greater than or equal to (\geq) 8 and less than or equal to (\leq) 9.5.
6. A1c is greater than or equal to (\geq) 7 and less than ($<$) 8
7. GPRAMA: Good control: A1c less than ($<$) 8.
8. A1c less than ($<$) 7.
9. Without result. Patients with A1c documented but no value.

2.1.3.5 Definitions

Diabetes

First Purpose of Visit ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.* recorded in the V POV file prior to the Report Period.

Serum Creatinine

- Site-populated taxonomy DM AUDIT CREATININE TAX
- LOINC taxonomy

Note: CPT codes are not included since they do not store the result, which is used in this topic.

A1c

Searches for most recent A1c test with a result during the Report Period. If more than one A1c test is found on the same day or the same visit and one test has a result and the other does not, the test with the result will be used. If both tests have a result, the last test done on the visit will be used.

If an A1c test with a result is not found, CRS searches for the most recent A1c test without a result.

- A1c defined as any of the following:
 - CPT 83036, 83037, 3044F through 3046F, 3047F (old code)
 - LOINC taxonomy
 - Site-populated taxonomy DM AUDIT HGB A1C TAX
- Without result is defined as A1c documented but with no value.

- CPT 3044F represents A1c less than (<) 7 and will be included in the A1c less than (<) 7 and A1c less than (<) 8 numerators.

2.1.3.6 GPRA 2016 Description

Good Glycemic Control: During GPRA Year 2016, achieve the target rate of 49.5% for the proportion of patients with diagnosed diabetes who have good glycemic control (defined as A1c less than (<) 7).

2.1.3.7 Patient List

List of diabetic patients with most recent A1c value, if any.

2.1.4 Diabetes: Blood Pressure Control

2.1.4.1 Owner and Contact

Diabetes Program: Dr. Ann Bullock

2.1.4.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.1.4.3 Denominators

1. User Population patients diagnosed with diabetes prior to the Report Period
2. GPRA: Active Diabetic patients, defined as Active Clinical patients diagnosed with diabetes prior to the Report Period, *and* at least two visits during the Report Period, *and* two DM-related visits ever.
3. Active Adult Diabetic patients, defined by meeting the following criteria:
 - Who are 19 and older at the beginning of the Report Period
 - Whose first ever DM diagnosis occurred prior to the Report Period
 - Who had at least two DM related visits ever
 - With at least one encounter with DM POV in a primary clinic with a primary provider during the Report Period
 - Never have had a creatinine value greater than (>) 5

2.1.4.4 Numerators

1. Patients with blood pressure documented during the Report Period.
2. **GPRA:** Patients with controlled blood pressure, defined as less than 140/90, i.e., the mean systolic value is less than (<) 140 *and* the mean diastolic value is less than (<) 90.
3. Patients with blood pressure that is not controlled.

2.1.4.5 Definitions

Diabetes

First DM Purpose of Visit ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.* recorded in the V POV file prior to the Report Period.

Serum Creatinine

- Site-populated taxonomy DM AUDIT CREATININE TAX
- LOINC taxonomy

Note: CPT codes are not included since they do not store the result, which is used in this topic.

Exclusions

When calculating all BPs (using vital measurements or CPT codes), the following visits will be excluded:

- Service Category H (Hospitalization), I (In Hospital), S (Day Surgery), or O (Observation)
- Clinic code 23 (Surgical), 30 (ER), 44 (Day Surgery), C1 (Neurosurgery), or D4 (Anesthesiology)

BP Documented

CRS uses mean of last three BPs documented during the Report Period. If three BPs are not available, uses mean of last two BPs, or one BP if there is only one documented. If a visit contains more than one BP, the lowest BP will be used, defined as having the lowest systolic value. The mean Systolic value is calculated by adding the last three (or two) systolic values and dividing by three (or two). The mean Diastolic value is calculated by adding the diastolic values from the last three (or two) BPs and dividing by three (or two).

If CRS is not able to calculate a mean BP, it will search for CPT 0001F, 2000F, 3074F through 3080F, G9273, G9274 or POV ICD-9: V81.1 documented during the Report Period.

Controlled BP

CRS uses a mean, as described previously where BP is less than (<) 140/90. If *both* the mean systolic and diastolic values do not meet the criteria for controlled, then the value is considered not controlled.

BP Documented and Controlled BP

If CRS is not able to calculate a mean BP from blood pressure measurements, it will search for the most recent of any of the following codes documented on non-ER visits during the Report Period:

- BP Documented: CPT 0001F, 2000F, G9273, G9274 or POV ICD-9: V81.1; OR
- Systolic: CPT 3074F, 3075F, or 3077F WITH Diastolic: CPT 3078F, 3079F, or 3080F. The systolic and diastolic values do not have to be recorded on the same day. If there are multiple values on the same day, the CPT indicating the lowest value will be used.
- The following combinations represent BP less than (<) 140/90 and will be included in the Controlled BP numerator: CPT 3074F or 3075F *and* 3078F or 3079F, OR G9273. All other combinations will *not* be included in the Controlled BP numerator.

2.1.4.6 GPRA 2016 Description

During GPRA Year 2016, achieve the target rate of 65.0% for the proportion of patients with diagnosed diabetes who have achieved BP control (defined as less than (<) 140/90).

2.1.4.7 Patient List

List of diabetic patients with blood pressure value, if any.

2.1.5 Statin Therapy to Reduce Cardiovascular Disease Risk in Patients with Diabetes**2.1.5.1 Owner and Contact**

Diabetes Program: Dr. Ann Bullock

2.1.5.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.1.5.3 Denominators

1. GPRA: Active Diabetic patients; defined as Active Clinical patients diagnosed with diabetes prior to the Report Period, *and* at least two visits in the past year, *and* two DM-related visits ever, ages 40 through 75 or age 21 and older with documented CVD or an LDL greater than or equal to (\geq) 190. Broken down by age groups. The key denominator for this and all diabetes-related topics is below.
2. Active Diabetic patients, defined as Active Clinical patients diagnosed with diabetes prior to the Report Period, AND at least 2 visits during the Report Period, AND 2 DM-related visits ever, ages 40 through 75.
3. Active Diabetic patients, defined as Active Clinical patients diagnosed with diabetes prior to the Report Period, AND at least 2 visits during the Report Period, AND 2 DM-related visits ever, ages 40 through 75 or age 21 and older with documented CVD or an LDL greater than or equal to (\geq) 190, including denominator exclusions.
4. User Population patients diagnosed with diabetes prior to the Report Period, ages 40 through 75 or age 21 and older with documented CVD or an LDL greater than or equal to (\geq) 190.

2.1.5.4 Numerators

1. GPRA: Patients who are statin therapy users during the Report Period or who receive an order (prescription) to receive statin therapy at any point during the Report Period.
2. Patients with any of the listed denominator exclusions.
 - A. Patients with documented allergy, intolerance, or other adverse effect to statin medication.

2.1.5.5 Definitions

Diabetes

First DM POV ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.* recorded in the V POV file prior to the Report Period.

Cardiovascular Disease (CVD)

Cardiovascular Disease (CVD) diagnosis defined as any of the following:

- Coronary Heart Disease (CHD) defined as any of the following:
 - POV ICD-9: 410.0-413.*, 414.0-414.9, 429.2; ICD-10: I20.0-I22.8, I24.0-I25.83, I25.89, I25.9, Z95.5

- Acute Myocardial Infarction (AMI) defined as any of the following:
 - POV ICD-9: 410.0*-410.9*, 412; ICD-10: I21.*, I22.*, I23.*, I25.2
- Ischemic Vascular Disease (IVD) defined as any of the following:
 - POV ICD-9: 411.*, 413.*, 414.0*, 414.2, 414.8, 414.9, 429.2, 433.*-434.*, 440.1, 440.2*, 440.4, 444.*, 445.*; ICD-10: I20.*, I24.*, I25.1*, I25.5-I25.812, I65.*, I66.*, I70.1, I70.201-I70.299, I70.92, I74.*, I75.*
- Ischemic Stroke or Transient Ischemic Attack (TIA) defined as any of the following:
 - POV ICD-9: 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9; ICD-10: G45.0-G45.2, G45.8, G45.9, G46.0-G46.2, I63.*
- Coronary Artery Bypass Graft (CABG) Procedure defined as any of the following:
 - POV ICD-9: V45.81; ICD-10: Z95.1
 - CPT 33510-33514, 33516-33519, 33521-33523, 33530, 33533-33536, 33572, 35500, 35600, S2205-S2209
 - Procedure ICD-9: 36.1*, 36.2*; ICD-10: 02100**, 021049*, 02104A*, 02104J*, 02104K*, 02104Z*, 02110**, 021149*, 02114A*, 02114J*, 02114K*, 02114Z*, 02120**, 021249*, 02124A*, 02124J*, 02124K*, 02124Z*, 02130**, 021349*, 02134A*, 02134J*, 02134K*, 02134Z*
- Percutaneous Coronary Interventions (PCI) Procedure defined as any of the following:
 - POV ICD-9: V45.82; ICD-10: Z95.5, Z98.61
 - CPT 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980 (old code), 92982 (old code), 92995 (old code), G0290, C9600, C9602, C9604, C9606, C9607
 - Procedure ICD-9: 00.66, 36.01 (old code), 36.02 (old code), 36.05 (old code), 36.06-36.07; ICD-10: 02703**, 02704**, 02713**, 02714**, 02723**, 02724**, 02733**, 02734**
- Other Revascularization:
 - CPT 37220, 37221, 37224-37231

LDL

For LDL greater than or equal to (\geq) 190, CRS will look for any test at any time with result greater than or equal to (\geq) 190. LDL defined as any of the following:

- LOINC taxonomy
- Site-populated taxonomy DM AUDIT LDL CHOLESTEROL TAX

Denominator Exclusions

Patients meeting any of the following conditions will be excluded from the denominator.

- Patients with documented allergy, intolerance, or other adverse effect to statin medication.
- Patients who have an active diagnosis of pregnancy or who are breastfeeding.
- Patients with a diagnosis of cirrhosis of the liver during the Report Period or the year prior to the Report Period.
- Patients who are receiving palliative care.
- Patients with end-stage renal disease (ESRD).
- Patients with diabetes whose most recent LDL result is less than (<) 70 and who have never had an LDL result greater than or equal to (>=) 190 and who are not taking statin therapy.

Contraindications to Statins

Contraindications to Statins defined as any of the following:

- Pregnancy: See the definition that follows
- Breastfeeding: See the definition that follows
- Acute Alcoholic Hepatitis: defined as POV ICD-9: 571.1; ICD-10: K70.10, K70.11 during the Report Period
- NMI refusal for any statin at least once during the Report Period.

Adverse drug reaction or documented statin allergy

Defined as any of the following:

- ALT or AST greater than three times the Upper Limit of Normal (ULN) (i.e., Reference High) on two or more consecutive visits during the Report Period
- Creatine Kinase (CK) levels greater than 10 times ULN or CK greater than 10,000 IU/L during the Report Period
- Myopathy or Myalgia, defined as any of the following during the Report Period:
 - POV ICD-9: 359.0 through 359.9, 729.1, 710.5, 074.1; ICD-10: G71.14, G71.19, G72.0, G72.2, G72.89, G72.9, M35.8, M60.80 through M60.9, M79.1
- Any of the following occurring ever:
 - POV ICD-9: 995.0 through 995.3 and E942.9
 - Statin or Statins entry in ART (Patient Allergies File)

- Statin or Statins contained within Problem List or in Provider Narrative field for any POV ICD-9: 995.0 through 995.3, V14.8; ICD-10: Z88.8

Pregnancy Definition

Any of the following:

- The Currently Pregnant field in Reproductive Factors file set to "Yes" during the Report Period
- At least two visits during the Report Period, where the primary provider is not a CHR (Provider code 53) with any of the following:
 - POV or Problem diagnosis ICD-9: 640.*3, 641.*3, 642.*3, 643.*3, 644.*3, 645.*3, 646.*3, 647.*3, 648.*3, 649.*3, 651.*3, 652.*3, 653.*3, 654.*3, 655.*3, 656.*3, 657.*3, 658.*3, 659.*3, 660.*3, 661.*3, 662.*3, 663.*3, 665.*3, 668.*3, 669.*3, 671.*3, 673.*3, 678.*3, 679.*3, V22.0 through V23.9, V24.*3, V27.*3, V28.81, V28.82, V28.89, V72.42, V89.01 through V89.09; ICD-10: O09.00 through O10.02, O10.111 through O10.12, O10.211 through O10.22, O10.311 through O10.32, O10.411 through O10.42, O10.911 through O10.92, O11.1 through O15.1, O15.9 through O24.02, O24.111 through O24.12, O24.311 through O24.32, O24.41*, O24.811 through O24.82, O24.911 through O24.92, O25.10 through O25.2, O26.00 through O26.62, O26.711 through O26.72, O26.811 through O26.93, O29.011 through O30.93, O31.*3 through O48.*3, O60.0*, O61.*3 through O66.*3, O68, O69.*3, O71.00 through O71.1, O71.89, O71.9, O74.0 through O75.81, O75.89, O75.9, O76 through O77.*3, O88.011 through O88.02, O88.111 through O88.12, O88.211 through O88.22, O88.311 through O88.32, O88.811 through O88.82, O90.3, O91.011 through O91.019, O91.111 through O91.119, O91.211 through O91.219, O92.011 through O92.019, O92.20, O92.29, O98.011 through O98.02, O98.111 through O98.12, O98.211 through O98.22, O98.311 through O98.32, O98.411 through O98.42, O98.511 through O98.52, O98.611 through O98.62, O98.711 through O98.72, O98.811 through O98.82, O98.911 through O98.92, O99.011 through O99.02, O99.111 through O99.12, O99.210 through O99.214, O99.280 through O99.284, O99.310 through O99.314, O99.320 through O99.324, O99.330 through O99.334, O99.340 through O99.344, O99.350 through O99.354, O99.411 through O99.42, O99.511 through O99.52, O99.611 through O99.62, O99.711 through O99.72, O99.810, O99.814, O99.820, O99.824, O99.830, O99.834, O99.840 through O99.844, O99.89, O9A.111 through O9A.12, O9A.211 through O9A.22, O9A.311 through O9A.32, O9A.411 through O9A.42, O9A.511 through O9A.52, Z03.7*, Z32.01, Z33.1, Z34.*3, Z36.
 - Procedure ICD-9: 72.*3, 73.*3, 74.*3

- CPT 59000-59076, 59300, 59320, 59400-59426, 59510, 59514, 59610, 59612, 59618, 59620, 76801-76828

Pharmacy-only visits (clinic code 39) will not count toward these two visits. If the patient has more than two pregnancy-related visits during the Report Period, CRS will use the first two visits in the Report Period.

The patient must not have a documented miscarriage or abortion occurring after the second pregnancy-related visit or the date the Currently Pregnant field was set to "Yes".

- **Miscarriage definition:**

- POV ICD-9: 630, 631, 632, 633*, 634*; ICD-10: O03.9
- CPT 59812, 59820, 59821, 59830

- **Abortion definition:**

- POV ICD-9: 635*, 636* 637*; ICD-10: O00.* through O03.89, O04.*, Z33.2
- CPT 59100, 59120, 59130, 59136, 59150, 59151, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260 through S2267,
- Procedure ICD-9: 69.01, 69.51, 74.91, 96.49; ICD-10: 0WHR73Z, 0WHR7YZ, 10A0***, 3E1K78Z, 3E1K88Z

Breastfeeding Definition

Any of the following documented during the Report Period:

- POV ICD-9: V24.1; ICD-10: Z39.1
- Breastfeeding Patient Education codes BF-BC, BF-BP, BF-CS, BF-EQ, BF-FU, BF-HC, BF-ON, BF-M, BF-MK, BF-N or containing SNOMED 169745008, 200430001, 405029003, 406213009, 413711008, 413712001

Palliative Care

- POV ICD-9: V66.7; ICD-10: Z51.5

Cirrhosis of the liver

- POV ICD-9: 571.2, 571.5, 571.6; ICD-10: K70.30, K70.31, K71.7, K74.3-K74.5, K74.60, K74.69, P78.81

ESRD

End Stage Renal Disease diagnosis or treatment defined as any of the following ever:

- CPT 36145 (old code), 36147, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831 through 36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90951 through 90970 or old codes 90918 through 90925, 90935, 90937, 90939 (old code), 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512, 3066F, G0257, G0308 through G0327 (old codes), G0392 (old code), G0393 (old code), G9231, S2065, S9339
- POV ICD-9: 585.6, V42.0, V45.1 (old code), V45.11, V45.12, V56.*; ICD-10: N18.6, Z48.22, Z49.*, Z91.15, Z94.0, Z99.2
- Procedure ICD-9: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93 through 39.95, 54.98, 55.6*

Statins Numerator Logic

- **Statin Therapy Users**
 - CPT 4013F
- **Statin medication codes**
 - Defined with medication taxonomy BGP PQA STATIN MEDS.
 - **Statin medications are:** Atorvastatin (Lipitor), Fluvastatin (Lescol), Lovastatin (Altacor, Altoprev, Mevacor), Pravastatin (Pravachol), Pitavastatin (Livalo), Simvastatin (Zocor), Rosuvastatin (Crestor).
- **Statin Combination Products**
 - Niacin-lovastatin, Niacin-simvastatin, Ezetimibe-simvastatin, Amlodipine-Atorvastatin, Sitagliptin-simvastatin, Ezetimibe-atorvastatin.

2.1.5.6 GPRA 2016 Target

During GPRA Year 2016, establish a baseline for the proportion of patients with diagnosed diabetes and cardiovascular disease who are on statin therapy.

2.1.5.7 Patient List

- List of diabetic patients with statin therapy or exclusion, if any.

2.1.6 Diabetes: Nephropathy Assessment**2.1.6.1 Owner and Contact**

Diabetes Program: Dr. Ann Bullock

2.1.6.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.1.6.3 Denominators

1. User Population patients diagnosed with diabetes prior to the Report Period.
2. GPRA: Active Diabetic patients; defined as Active Clinical patients diagnosed with diabetes prior to the Report Period, *and* at least two visits in the past year, *and* two DM-related visits ever. Key denominator for this and all diabetes-related topics that follow.
3. Active Adult Diabetic patients, defined by meeting the following criteria:
 - Who are 19 and older at the beginning of the Report Period
 - Whose first ever DM diagnosis occurred prior to the Report Period
 - Who had at least two DM related visits ever
 - With at least one encounter with DM POV in a primary clinic with a primary provider during the Report Period
 - Never have had a creatinine value greater than (>) 5

2.1.6.4 Numerators

1. GPRA: Patients with nephropathy assessment, defined as an estimated Glomerular Filtration Rate (GFR) with result *and* a Urine Albumin-to-Creatinine Ratio (UACR) during the Report Period *or* with evidence of diagnosis or treatment of end-stage renal disease (ESRD) at any time before the end of the Report Period.

2.1.6.5 Definitions

Diabetes

First DM POV ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.* recorded in the V POV file prior to the Report Period.

Serum Creatinine

- Site-populated taxonomy DM AUDIT CREATININE TAX, or
- LOINC taxonomy

Note: CPT codes are not included since they do not store the result, which is used in this topic.

Estimated GFR

- Site-populated taxonomy BGP GPRA ESTIMATED GFR TAX or
- LOINC taxonomy

Urine Albumin-to-Creatinine Ratio

- CPT 82043 WITH 82570
- LOINC taxonomy, or
- Site-populated taxonomy BGP QUANT UACR TESTS

Note: Check with your laboratory supervisor to confirm that the names you add to your taxonomy reflect quantitative test values.

ESRD

- End Stage Renal Disease diagnosis or treatment defined as any of the following ever:
 - CPT 36145 (old code), 36147, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831 through 36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90951 through 90970 or old codes 90918 through 90925, 90935, 90937, 90939 (old code), 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512, 3066F, G0257, G0308 through G0327 (old codes), G0392 (old code), G0393 (old code), G9231, S2065, S9339
 - POV ICD-9: 585.6, V42.0, V45.1 (old code), V45.11, V45.12, V56.*; ICD-10: N18.6, Z48.22, Z49.*, Z91.15, Z94.0, Z99.2
 - Procedure ICD-9: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93 through 39.95, 54.98, 55.6*

2.1.6.6 GPRA 2016 Description

During GPRA Year 2016, achieve the target rate of 61.1% for the proportion of patients with diagnosed diabetes who are assessed for nephropathy.

2.1.6.7 Patient List

List of diabetic patients with nephropathy assessment, if any.

2.1.7 Diabetic Retinopathy**2.1.7.1 Owner and Contact**

Diabetes Program: Dr. Mark Horton

2.1.7.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.1.7.3 Denominators

1. User Population patients diagnosed with diabetes prior to the Report Period, without a documented history of bilateral blindness.
2. GPRA: Active Diabetic patients; defined as Active Clinical patients diagnosed with diabetes prior to the Report Period, *and* at least two visits in the past year, *and* two DM-related visits ever, without a documented history of bilateral blindness. Key denominator for this and all diabetes-related topics that follow.
3. Active Adult Diabetic patients, without a documented history of bilateral blindness, defined by meeting the following criteria:
 - Who are 19 and older at the beginning of the Report Period
 - Whose first ever DM diagnosis occurred prior to the Report Period
 - Who had at least two DM related visits ever
 - With at least one encounter with DM POV in a primary clinic with a primary provider during the Report Period
 - Never have had a creatinine value greater than (>) 5

2.1.7.4 Numerators

1. GPRA: Patients receiving a qualified retinal evaluation during the Report Period.

Note: This numerator does *not* include refusals.

- A. Patients receiving diabetic retinal exam during the Report Period.
- B. Patients receiving other eye exams during the Report Period.
- C. Patients with a validated teleretinal⁸ visit during the Report Period.
- D. Patients with an Ophthalmology visit during the Report Period.
- E. Patients with an Optometry visit during the Report Period.

⁸ Validation study properly powered and controlled against the ETDRS gold standard (American Telemedicine Association validation category 3).

2.1.7.5 Definitions

Diabetes

First DM Purpose of Visit ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.* recorded in the V POV file prior to the Report Period.

Serum Creatinine

Either of the following:

- Site-populated taxonomy DM AUDIT CREATININE TAX
- LOINC taxonomy

Note: CPT codes are not included since they do not store the result, which is used in this topic.

Qualified Retinal Evaluation

- Diabetic retinal exam
- Other eye exam.

The following methods are qualifying for this measure:

- Dilated retinal evaluation by an optometrist or ophthalmologist.
- Seven standard fields stereoscopic photos (ETDRS) evaluated by an optometrist or ophthalmologist.
- Any photographic method formally validated⁹ to seven standard fields (ETDRS).

Diabetic Retinal Exam

Any of the following during the Report Period:

- Exam code 03 Diabetic Eye Exam (dilated retinal examination or formally validated¹⁰ ETDRS photographic equivalent)
- CPT 2022F Dilated retinal eye exam, 2024F Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist, 2026F Eye imaging formally validated¹¹ to match the diagnosis from 7 standard field stereoscopic photos, S0620 Routine ophthalmological examination including refraction; new patient, S0621 Routine ophthalmological examination

⁹ Ibid.

¹⁰ Validation study properly powered and controlled against the ETDRS gold standard (American Telemedicine Association validation category 3).

¹¹ Ibid.

including refraction; established patient, or S3000 Diabetic indicator; retinal eye exam, dilated, bilateral.

Other Eye Exam

- Non-DNKA (did not keep appointment) visits to ophthalmology or optometry clinics with an optometrist or ophthalmologist, or visits to formally validated¹² teleophthalmology retinal evaluation clinics. Searches for the following codes in the following order:
 - CPT 67028, 67038 (old code), 67039, 67040, 92002, 92004, 92012, 92014
 - Clinic code A2 (Diabetic Retinopathy)¹³
 - Clinic codes 17¹⁴ or 18¹⁵ with Provider code 08, 24, or 79 where the Service Category is not C (Chart Review) or T (Telecommunications).

JVN Visit

- Clinic code A2

Ophthalmology Visit

- Clinic code 17 with Provider code 79 where the Service Category is not C (Chart Review) or T (Telecommunications)

Optometry Visit

- Clinic code 18 with Provider codes 08 or 24 where the Service Category is not C (Chart Review) or T (Telecommunications)

Bilateral Blindness

- Diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 369.01, 369.03, 369.04; ICD-10: H54.0 through H54.12

2.1.7.6 GPRA 2016 Description:

During GPRA Year 2016, achieve the target rate of 61.6% for the proportion of patients with diagnosed diabetes who receive an annual retinal examination.

2.1.7.7 Patient List

List of diabetic patients with qualified retinal evaluation, if any.

¹² Ibid.

¹³ Validated photographic (teleretinal) retinal surveillance (American Telemedicine Association validation category 3).

¹⁴ Ophthalmology or Optometry clinic codes (17, 18) cannot be used for non-qualifying photographic DR examination methods⁹ unless a dilated retinal examination by an ophthalmologist or optometrist is also accomplished during the same encounter.

¹⁵ Ibid.

2.1.8 Diabetic Access to Dental Services

2.1.8.1 Owner and Contact

Dental Program: Timothy L. Lozon, D.D.S., Tim Ricks, DMD, Carol Bassim, DMD, MHS

2.1.8.2 National Reporting

Not reported nationally

2.1.8.3 Denominators

1. Active Diabetic patients; defined as Active Clinical patients diagnosed with diabetes prior to the Report Period, *and* at least two visits during the Report Period, *and* two DM-related visits ever.

2.1.8.4 Numerators

1. Patients with a documented dental visit during the Report Period.

Note: This numerator does *not* include refusals.

2.1.8.5 Definitions

Diabetes

First DM POV ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.* recorded in the V POV file prior to the Report Period.

Documented Dental Visit

For non-PRC visits, searches for any of the following:

- Dental ADA code 0000, 0190, 0191
- CPT code D0190, D0191
- Exam code 30
- POV ICD-9: V72.2; ICD-10: Z01.20, Z01.21

For PRC dental visits, searches for any visit with an ADA code. PRC visit defined as Type code of C in Visit file.

2.1.8.6 Patient List

List of diabetic patients and documented dental visit, if any.

2.2 Dental Group

2.2.1 Access to Dental Services

2.2.1.1 Owner and Contact

Dental Program: Timothy L. Lozon, D.D.S., Tim Ricks, DMD, Carol Bassim, DMD, MHS

2.2.1.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.2.1.3 Denominators

1. GPRA: User Population patients. Broken down by age groups: 0 through 5 years, 6 through 21 years, 22 through 34 years, 35 through 44 years, 45 through 54 years, 55 through 74 years, 75 years and older.

2.2.1.4 Numerators

1. GPRA: Patients with documented dental visit during the Report Period.

Note: This numerator does *not* include refusals.

2.2.1.5 Definitions

Documented Dental Visit

For non-PRC dental visits, searches for any of the following:

- Dental ADA codes 0000, 0190, 0191
- CPT code D0190, D0191
- Exam 30
- POV ICD-9: V72.2; ICD-10: Z01.20, Z01.21

For PRC dental visits, searches for any visit with an ADA code. PRC visit defined as Type code of C in Visit file.

2.2.1.6 GPRA 2016 Description

During GPRA Year 2016, achieve the target rate of 29.3% for the proportion of patients who receive dental services.

2.2.1.7 Patient List

List of patients with documented dental visit and date.

2.2.2 Dental Sealants

2.2.2.1 Owner and Contact

Dental Program: Timothy L. Lozon, D.D.S., Tim Ricks, DMD, Carol Bassim, DMD, MHS

2.2.2.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.2.2.3 Denominators

1. GPRA: User Population patients ages 2 through 15. Broken down by age groups: 3 through 5, 6 through 9, 10 through 12, 13 through 15, and 5 through 19.

2.2.2.4 Numerators

1. GPRA: Patients with at least one or more intact dental sealants.
2. Count only (no percentage comparison to denominator). For patients meeting the User Population definition, the total number of dental sealants during the Report Period. Broken down by age group 2 through 15.

Note: This numerator does *not* include refusals.

2.2.2.5 Definitions

Intact Dental Sealant

- Any of the following documented during the Report Period:
 - Dental ADA codes 1351, 1352, 1353
 - CPT codes D1351, D1352, D1353
- OR any of the following documented during the past 3 years from the end of the Report Period, as long as it is not documented on the same visit as any of the above codes:
 - Dental ADA code 0007

If both ADA and CPT codes are found on the same visit, only the ADA will be counted.

For the count measure, only two sealants per tooth and only one repair (ADA code 1353 or CPT D1353) per tooth will be counted during the Report Period. Each tooth is identified by the data element Operative Site in RPMS.

2.2.2.6 GPRA 2016 Description

During GPRA Year 2016, achieve the target rate of 14.8% for the proportion of patients with at least one or more intact dental sealants.

2.2.2.7 Patient List

List of patients with intact dental sealants.

2.2.3 Topical Fluoride

2.2.3.1 Owner and Contact

Dental Program: Timothy L. Lozon, D.D.S., Tim Ricks, DMD, Carol Bassim, DMD, MHS

2.2.3.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.2.3.3 Denominators

1. GPRA: User Population patients ages 1 through 15.

2.2.3.4 Numerators

1. GPRA: Patients who received one or more topical fluoride applications during the Report Period.
2. Count only (no percentage comparison to denominator). For patients meeting the User Population definition, the total number of patients with at least one topical fluoride treatment during the Report Period. Broken down by age group 1 through 15.

Note: This numerator does *not* include refusals.

3. Count only (no percentage comparison to denominator). For patients meeting the User Population definition, the total number of appropriate topical fluoride applications based on a maximum of four per patient per year.

2.2.3.5 Definitions

Topical Fluoride Application

Defined as any of the following:

- Dental ADA codes 1201 (old code), 1203 (old code), 1204 (old code), 1205 (old code), 1206, 1208, 5986
- CPT codes D1203 (old code), D1204 (old code), D1206, D1208, D5986, 99188
- POV ICD-9: V07.31

For the count measure, a maximum of one application per patient per visit is allowed. A maximum of four topical fluoride applications are allowed per patient per year for the applications measure.

2.2.3.6 GPRA 2016 Description

During GPRA Year 2016, achieve the target rate of 28.3% for the proportion of patients who received one or more topical fluoride applications.

2.2.3.7 Patient List

List of patients who received at least one topical fluoride application during Report Period.

2.3 Immunization Group

2.3.1 Influenza

2.3.1.1 Owner and Contact

Epidemiology Program: Amy Groom, MPH

2.3.1.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.3.1.3 Denominators

1. Active Clinical patients broken down by age groups: 6 months through 17 years, 18 years and older, 18 through 49 years, 50 through 64 years, 65 years and older.
 - A. GPRA: Active Clinical patients ages 6 months to 17 years.
 - B. GPRA: Active Clinical patients ages 18 years and older.
2. Active Clinical patients ages 18 through 49 years and considered high risk for influenza.
3. Active Diabetic patients, defined as Active Clinical patients diagnosed with diabetes prior to the Report Period, *and* at least two visits during the Report Period, *and* two DM-related visits ever.
4. User Population patients broken down by age groups: 6 months through 17 years, 18 years and older, 18 through 49 years, 50 through 64 years, 65 years and older.
5. User Population patients ages 18 through 49 years and considered high risk for influenza

2.3.1.4 Numerators

1. GPRA: Patients with influenza vaccine documented during the Report Period or with a contraindication documented at any time before the end of the Report Period.

Note: The only refusals included in this numerator are not medically indicated (NMI) refusals.

- A. Patients with a contraindication or a documented NMI refusal.

2.3.1.5 Definitions

Diabetes

First DM Purpose of Visit ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.* recorded in the V POV file prior to the Report Period.

Influenza Vaccine

Any of the following during the Report Period:

- Immunization (CVX) codes 15, 16, 88, 111, 135, 140, 141, 144, 149, 150, 151, 153, 155, 158, 161, 166
- POV ICD-9: V04.8 (old code), V04.81 *not* documented with 90663, 90664, 90666 through 90668, 90470, G9141 or G9142, or V06.6 *not* documented with 90663, 90664, 90666 through 90668, 90470, G9141 or G9142

- CPT 90630, 90654 through 90662, 90672, 90673, 90685 through 90688, 90724 (old code), G0008, G8108 (old code)

Contraindication to Influenza Vaccine

Any of the following documented at any time before the end of the Report Period:

- Contraindication in the Immunization Package of “Egg Allergy” or “Anaphylaxis”
- PCC NMI Refusal

Persons Considered High Risk for Influenza

Those who have two or more visits in the past 3 years with a POV or Problem diagnosis of any of the following:

- HIV Infection: ICD-9: 042, 042.0 through 044.9 (old codes), 079.53, V08; ICD-10: B20, B52.0, B97.35, Z21
- Diabetes: ICD-9: 250.00 through 250.93; ICD-10: E08.2*, E09.2*, E10.* through E13.*
- Rheumatic Heart Disease: ICD-9: 393. through 398.99; ICD-10: I05.* through I09.*
- Hypertensive Heart Disease: ICD-9: 402.00 through 402.91; ICD-10: I11.*
- Hypertensive Heart or Renal Disease: ICD-9: 404.00 through 404.93; ICD-10: I13.*
- Ischemic Heart Disease: ICD-9: 410.00 through 414.9; ICD:10: I20.0 through I22.8, I24.0 through I25.83, I25.89, I25.9
- Pulmonary Heart Disease: ICD-9: 415.0 through 416.9; ICD-10: I26.* through I27.*
- Other Endocardial Heart Disease: ICD-9: 424.0 through 424.9; ICD-10: I34.* through I39
- Cardiomyopathy: ICD-9: 425.0 through 425.9; ICD-10: I42.*, I43
- Congestive Heart Failure: ICD-9: 428.0 through 428.9, 429.2; ICD-10: I50.1, I50.20, I50.22 through I50.30, I50.32 through I50.40, I50.42 through I50.9
- Chronic Bronchitis: ICD-9: 491.0 through 491.9; ICD-10: J41.*, J42
- Emphysema: ICD-9: 492.0 through 492.8; ICD-10: J43.*
- Asthma: ICD-9: 493.00 through 493.91; ICD-10: J45.21 through J45.902
- Bronchiectasis, CLD, COPD: ICD-9: 494.0 through 496.; ICD-10: J44.*, J47.*

- Pneumoconioses: ICD-9: 500 through 505; ICD-10: J60 through J64, J66.8 through J67.6, J67.8 through J67.9
- Chronic Liver Disease: ICD-9: 571.0 through 571.9; ICD-10: K70.11 through K70.41, K73.0 through K74.5, K74.69, K75.81
- Nephrotic Syndrome: ICD-9: 581.0 through 581.9; ICD-10: N02.*, N04.*, N08
- Renal Failure: ICD-9: 585.6, 585.9; ICD-10: N18.6 through N19
- Transplant: ICD-9: 996.80 through 996.89; ICD-10: T86.00 through T86.819, T86.83*, T86.850 through T86.899, Z48.21 through Z48.280, Z48.290, Z94.0 through Z94.4, Z94.6, Z94.81 through Z94.84, Z95.3, Z95.4
- Kidney Transplant: ICD-9: V42.0 through V42.89
- Chemotherapy: ICD-9: V58.1; ICD-10: Z51.11, Z51.12
- Chemotherapy follow-up: ICD-9: V67.2; ICD-10: Z08

2.3.1.6 GPRA 2016 Description

Children: During GPRA Year 2016, establish a baseline for the proportion of patients age 6 months to 17 years who receive an influenza immunization.

Adults: During GPRA Year 2016, establish a baseline for the proportion of patients age 18 years and older who receive an influenza immunization.

2.3.1.7 Patient List

List of patients with Influenza code, if any.

2.3.2 Adult Immunizations

2.3.2.1 Owner and Contact

Epidemiology Program: Amy Groom, MPH

2.3.2.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.3.2.3 Denominators

1. Active Clinical patients ages 19 through 59.

2. Active Clinical patients ages 60 through 64.
3. GPRA: Active Clinical patients ages 65 and older.
4. Active Clinical patients ages 18 through 64 years and considered high risk for pneumococcal.
5. Active Diabetic patients, defined as Active Clinical patients diagnosed with diabetes prior to the Report Period, *and* at two visits during the Report Period, *and* two DM-related visits ever.
6. User Population patients ages 19 through 59.
7. User Population patients ages 60 through 64.
8. User Population patients ages 65 years and older.
9. User Population patients ages 18 through 64 years and considered high risk for pneumococcal.
10. Active Clinical patients ages 18 and older. Broken down by age groups: 18 through 64.
11. User Population patients ages 18 and older. Broken down by age groups: 18 through 64.

2.3.2.4 Numerators

1. Patients who have received one dose of Tdap or Td in the past 10 years, including contraindications.

Note: The only refusals included in this numerator are NMI refusals.

A. Patients with a contraindication or a documented NMI refusal

2. Patients who have received one dose of Tdap ever, including contraindications.

Note: The only refusals included in this numerator are NMI refusals.

A. Patients with a contraindication or a documented NMI refusal

3. Patients with influenza vaccine documented during the Report Period or with a contraindication documented at any time before the end of the Report Period.

Note: The only refusals included in this numerator are NMI refusals.

- A. Patients with a contraindication or a documented NMI refusal
4. Patients who have received one dose of Zoster ever, including contraindications.

Note: The only refusals included in this numerator are NMI refusals.

- A. Patients with a contraindication or a documented NMI refusal
5. GPRA: Patients with Pneumococcal vaccine or contraindication documented ever and, if patient is older than 65 years, either a dose of pneumococcal vaccine after the age of 65 or a dose of pneumococcal vaccine in the past 5 years.

Note: The only refusals included in this numerator are NMI refusals.

- A. Patients with a contraindication or a documented NMI refusal
6. Patients who have received the 1:1:1 combination (i.e., one Tdap/Td in the past 10 years, one Tdap ever, one influenza during the Report Period), including contraindications.

Note: The only refusals included in this numerator are NMI refusals.

- A. Patients with a contraindication or a documented NMI refusal
7. Patients who have received the 1:1 combination (i.e., one Tdap/Td in the past 10 years, one Tdap ever), including contraindications.

Note: The only refusals included in this numerator are NMI refusals.

- A. Patients with a contraindication or a documented NMI refusal
8. Patients who have received the 1:1:1:1 combination (i.e., one Tdap/Td in the past 10 years, one Tdap ever, one influenza during the Report Period, one Zoster ever), including contraindications.

Note: The only refusals included in this numerator are NMI refusals.

- A. Patients with a contraindication or a documented NMI refusal
9. Patients who have received the 1:1:1 combination (i.e., one Tdap/Td in the past 10 years, one Tdap ever, one Zoster ever), including contraindications

Note: The only refusals included in this numerator are NMI refusals.

A. Patients with a contraindication or a documented NMI refusal

10. Patients who have received the 1:1:1:1:1 combination (i.e., one Tdap/Td in the past 10 years, one Tdap ever, one influenza during the Report Period, one Zoster ever, one up-to-date pneumococcal vaccine), including contraindications.

Note: The only refusals included in this numerator are NMI refusals.

A. Patients with a contraindication or a documented NMI refusal

11. Patients who have received the 1:1:1:1 combination (i.e., one Tdap/Td in the past 10 years, one Tdap ever, one Zoster ever, one up-to-date pneumococcal vaccine), including contraindications.

Note: The only refusals included in this numerator are NMI refusals.

A. Patients with a contraindication or a documented NMI refusal

12. Patients with Pneumococcal vaccine or contraindication documented at any time before the end of the Report Period.

Note: The only refusals included in this numerator are NMI refusals.

2.3.2.5 Definitions

Diabetes

First DM POV ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.* recorded in the V POV file prior to the Report Period.

Pneumococcal Vaccine

Any of the following documented any time before the end of the Report Period:

- Immunization (CVX) codes 33, 100, 109, 133, 152
- POV ICD-9: V06.6, V03.82
- CPT 90669, 90670, 90732, G0009, G8115 (old code), G9279

Pneumococcal Contraindication

Any of the following documented any time before the end of the Report Period:

- Contraindication in the Immunization Package of “Anaphylaxis”

- PCC NMI Refusal

Persons Considered High Risk for Pneumococcal

Those who have two or more visits in the past three years with a POV or Problem diagnosis of any of the following:

- HIV Infection: ICD-9: 042, 042.0 through 043.9 (old codes), 044.9 (old code), 079.53, V08; ICD-10: B20, B52, B97.35, Z21
- Diabetes: ICD-9: 250.00 through 250.93; ICD-10: E08.2*, E09.2*, E10.* through E13.*
- Chronic alcoholism: ICD-9: 303.90, 303.91; ICD-10: F10.20, F10.22 through F10.29
- Congestive Heart Failure: ICD-9: 428.0 through 428.9, 429.2; ICD-10: I50.1, I50.20, I50.22 through I50.30, I50.32 through I50.40, I50.42 through I50.9
- Emphysema: ICD-9: 492.0 through 492.8; ICD-10: J43.*
- Asthma: ICD-9: 493.00 through 493.91; ICD-10: J45.21 through J45.902
- Bronchiectasis, CLD, COPD: ICD-9: 494. through 496.; ICD-10: J44.*, J47.*
- Pneumoconioses: ICD-9: 501. through 505.; ICD-10: J60 through J64, J66.8 through J67.6, J67.8 through J67.9
- Chronic Liver Disease: ICD-9: 571.0 through 571.9; ICD-10: K70.11 through K70.41, K73.0 through K74.5, K74.69, K75.81
- Nephrotic Syndrome: ICD-9: 581.0 through 581.9; ICD-10: N02.*, N04.*, N08
- Renal Failure: ICD-9: 585.6, 585.9; ICD-10: N18.6 through N19
- Injury to spleen: ICD-9: 865.00 through 865.19
- Transplant: ICD-9: 996.80 through 996.89; ICD-10: T86.00 through T86.819, T86.83*, T86.850 through T86.899, Z48.21 through Z48.280, Z48.290, Z94.0 through Z94.4, Z94.6, Z94.81 through Z94.84, Z95.3, Z95.4
- Kidney Transplant: ICD-9: V42.0 through V42.89
- Chemotherapy: ICD-9: V58.1; ICD-10: Z51.11, Z51.12
- Chemotherapy follow-up: ICD-9: V67.2; ICD-10: Z08

Tdap Immunization:

Any of the following documented during the applicable time frame:

- Immunization (CVX) code: 115
- CPT 90715

Tdap Contraindication

Any of the following documented any time before the end of the Report Period:

- Immunization Package contraindication of "Anaphylaxis"
- PCC NMI Refusal

Td Immunization

Any of the following documented in the past 10 years:

- Immunization (CVX) code 9, 113, 138, 139
- POV ICD-9: V06.5
- CPT 90714, 90718

Td Contraindication

Any of the following documented any time before the end of the Report Period:

- Immunization Package contraindication of "Anaphylaxis"
- PCC NMI Refusal

Influenza Vaccine

Any of the following during the Report Period:

- Immunization (CVX) codes 15, 16, 88, 111, 135, 140, 141, 144, 149, 150, 151, 153, 155, 158, 161, 166
- POV ICD-9: V04.8 (old code), V04.81 *not* documented with 90663, 90664, 90666 through 90668, 90470, G9141 or G9142, or V06.6 *not* documented with 90663, 90664, 90666 through 90668, 90470, G9141 or G9142
- CPT 90630, 90654 through 90662, 90672, 90673, 90685 through 90688, 90724 (old code), G0008, G8108 (old code)

Contraindication to Influenza Vaccine

Any of the following documented at any time before the end of the Report Period:

- Contraindication in the Immunization Package of "Egg Allergy" or "Anaphylaxis"
- PCC NMI Refusal

Zoster Vaccine

Any of the following documented ever:

- Immunization (CVX) codes 121
- CPT 90736

Contraindication to Zoster Vaccine

Any of the following documented at any time before the end of the Report Period:

- Contraindication in the Immunization Package of “Immune Deficiency” or “Anaphylaxis”
- PCC NMI Refusal

2.3.2.6 GPRA 2016 Description

During GPRA Year 2016, achieve the target rate of 87.3% for the proportion of adult patients age 65 years and older who receive a pneumococcal immunization.

2.3.2.7 Patient List

List of patients 18 years and older or DM diagnosis with IZ or contraindication, if any.

2.3.3 Childhood Immunizations**2.3.3.1 Owner and Contact**

Epidemiology Program: Amy Groom, MPH

2.3.3.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.3.3.3 Denominators

1. Active Clinical patients ages 19 through 35 months at end of Report Period.
2. GPRAMA: User Population patients active in the Immunization Package who are 19 through 35 months of age at end of Report Period.

Note: Sites must be running the RPMS Immunization package for this denominator. Sites not running the package will have a value of zero for this denominator.

2.3.3.4 Numerators

1. GPRAMA: Patients who have received the 4:3:1:3*:3:1:4 combination (i.e., four DTaP, three Polio, one MMR, three or four HiB, three Hepatitis B, one Varicella, and four Pneumococcal), including contraindications, and evidence of disease.

Note: The only refusals included in this numerator are NMI refusals.

- A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.
2. Patients who have received four doses of DTaP ever, including contraindications.

Note: The only refusals included in this numerator are NMI refusals.

- A. Patients with (1) a contraindication or (2) a documented NMI refusal.
3. Patients who have received three doses of Polio ever, including contraindications, and evidence of disease.

Note: The only refusals included in this numerator are NMI refusals.

- A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.
4. Patients who have received one dose of MMR ever, including contraindications, and evidence of disease.

Note: The only refusals included in this numerator are NMI refusals.

- A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.
5. Patients who have received three or four doses of HiB ever, including contraindications.

Note: The only refusals included in this numerator are NMI refusals.

- A. Patients with (1) a contraindication or (2) a documented NMI refusal.
6. Patients who have received three doses of Hepatitis B vaccine ever, including contraindications, and evidence of disease.

Note: The only refusals included in this numerator are NMI refusals.

- A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.

7. Patients who have received one dose of Varicella ever, including contraindications, and evidence of disease.

Note: The only refusals included in this numerator are NMI refusals.

- A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.

8. Patients who have received four doses of Pneumococcal conjugate vaccine ever, including contraindications.

Note: The only refusals included in this numerator are NMI refusals.

- A. Patients with (1) a contraindication or (2) a documented NMI refusal.

9. Patients who have received one dose of Hepatitis A vaccine ever, including contraindications and evidence of disease.

Note: The only refusals included in this numerator are NMI refusals.

- A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.

10. Patients who have received two or three doses of Rotavirus vaccine ever, including contraindications.

Note: The only refusals included in this numerator are NMI refusals.

- A. Patients with (1) a contraindication or (2) a documented NMI refusal.

11. Patients who have received two doses of Influenza ever, including contraindications.

Note: The only refusals included in this numerator are NMI refusals.

- A. Patients with (1) a contraindication or (2) a documented NMI refusal.

2.3.3.5 Definitions

Patient Age

Since the age of the patient is calculated at the beginning of the Report Period, the age range will be adjusted to 7 through 23 months at the beginning of the Report Period, which makes the patient between the ages of 19 through 35 months at the end of the Report Period.

Timing of Doses

Because IZ data comes from multiple sources, any IZ codes documented on dates within 10 days of each other will be considered as the same immunization.

Active Immunization Package Patients Denominator

Same as User Population definition *except* includes only patients flagged as active in the Immunization Package.

Note: Only values for the Report Period will be reported for this denominator since currently there is not a way to determine if a patient was active in the Immunization Package during the previous year or baseline periods.

Dosage and Types of Immunizations

- **Four Doses of DTaP**
 - Four DTaP or DTP or Tdap
 - One DTaP or DTP or Tdap and three DT or Td
 - One DTaP or DTP or Tdap and three each of Diphtheria and Tetanus
 - Four DT and four Acellular Pertussis
 - Four Td and four Acellular Pertussis
 - Four each of Diphtheria, Tetanus, and Acellular Pertussis
- **Three Doses of Polio**
 - Three OPV
 - Three IPV
 - Combination of OPV and IPV totaling three doses
- **One Dose of MMR**
 - MMR
 - One M/R and one Mumps
 - One R/M and one Measles
 - One each of Measles, Mumps, and Rubella
- **Three doses of Hepatitis B**

- **Three or four doses of HIB**
- **One dose of Varicella**
- **Four doses of Pneumococcal**
- **One dose of Hepatitis A**
- **Two or three doses of Rotavirus, depending on the vaccine administered**
- **Two doses of Influenza**

Not Medically Indicated (NMI) Refusal, Contraindication, and Evidence of Disease Information

Except for the Immunization Program Numerators, the following will also count toward meeting the definition, as defined in the following subsections:

- NMI refusals
- Evidence of disease
- Contraindications for individual immunizations

Note: NMI refusals are not counted as refusals; rather, they are counted as contraindications.

- For immunizations that allow a different number of doses (e.g., two or three Rotavirus): To count toward the numerator with the smaller number of doses, all of the patient's vaccinations must be part of the smaller dose series. For example, for a patient to count toward the Rotavirus numerator with only two doses, all two doses must be included in the two-dose series codes listed in the Rotavirus definition. A patient with a mix of two-dose and three-dose series codes will need three doses to count toward the numerator. An exception to this is for the HIB vaccine: if the first two doses are CVX code 49, then the patient only needs three doses (even if the third dose is included in the 4-dose series).
- Each immunization must be refused and documented separately. For example, if a patient has an NMI refusal for Rubella only, then there must be an immunization, contraindication, or separate NMI refusal for the Measles and Mumps immunizations.
- For immunizations where required number of doses is greater than one, only one NMI refusal is necessary to be counted in the numerator. For example, if there is a single NMI refusal for Hepatitis B, the patient will be included in the numerator.
- For immunizations where required number of doses is greater than one, only one contraindication is necessary to be counted in the numerator. For

example, if there is a single contraindication for HiB, the patient will be included in the numerator.

- Evidence of disease will be checked for at any time in the child's life (prior to the end of the Report Period).
- To be counted in Subnumerator A, a patient must meet the numerator definition AND have evidence of disease, a contraindication, or an NMI refusal for any of the immunizations in the numerator. For example, if a patient was Rubella immune but had a Measles and Mumps immunization, the patient would be included in Subnumerator A.
- For the separate numerator for REF refusal (Patient Refusal for Service) in PCC or a Parent or Patient refusal in the IZ program, the conditions must be met:
 - Each immunization must be refused and documented separately. For example, if a patient has an REF refusal for Rubella, then there also must be an immunization, contraindication, or separate REF refusal for Measles and Mumps.
 - Where the required number of doses is greater than one, only one REF refusal in PCC or one Parent or Patient refusal in the IZ program is necessary to be counted in the numerator. For example, for the four DTaP numerators, only one refusal is necessary to be counted in the refusal numerator.

NMI Refusal Definitions

PCC Refusal type NMI for any of the following codes:

- **DTaP**
 - Immunization (CVX) codes 20, 50, 102, 106, 107, 110, 120, 130, 132, 146
 - CPT 90696, 90698, 90700, 90721, 90723
- **DTP**
 - Immunization (CVX) codes 1, 22, 102
 - CPT 90701, 90711 (old code), 90720
- **Tdap**
 - Immunization (CVX) code 115
 - CPT 90715
- **DT**
 - Immunization (CVX) code 28
 - CPT 90702
- **Td**

- Immunization (CVX) codes 9, 113, 138, 139
- CPT 90714, 90718
- **Diphtheria**
 - CPT 90719
- **Tetanus**
 - Immunization (CVX) codes 35, 112
 - CPT 90703
- **Acellular Pertussis**
 - Immunization (CVX) code 11
- **OPV**
 - Immunization (CVX) codes 2, 89
 - CPT 90712
- **IPV**
 - Immunization (CVX) codes 10, 89, 110, 120, 130, 132, 146
 - CPT 90696, 90698, 90711 (old code), 90713, 90723
- **MMR**
 - Immunization (CVX) codes 3, 94
 - CPT 90707, 90710
- **M/R**
 - Immunization (CVX) code 4
 - CPT 90708
- **R/M**
 - Immunization (CVX) code 38
 - CPT 90709 (old code)
- **Measles**
 - Immunization (CVX) code 5
 - CPT 90705
- **Mumps**
 - Immunization (CVX) code 7
 - CPT 90704
- **Rubella**
 - Immunization (CVX) code 6
 - CPT 90706

- **HiB**
 - Immunization (CVX) codes 17, 22, 46 through 49, 50, 51, 102, 120, 132, 146
 - CPT 90645 through 90648, 90698, 90720 through 90721, 90737 (old code), 90748
- **Hepatitis B**
 - Immunization (CVX) codes 8, 42 through 45, 51, 102, 104, 110, 132, 146
 - CPT 90636, 90723, 90731 (old code), 90740, 90743 through 90748, G0010, Q3021 (old code), Q3023 (old code)
- **Varicella**
 - Immunization (CVX) codes 21, 94
 - CPT 90710, 90716
- **Pneumococcal**
 - Immunization (CVX) codes 33, 100, 109, 133, 152
 - CPT 90669, 90670, 90732, G0009, G8115 (old code), G9279
- **Hepatitis A**
 - Immunization (CVX) codes 31, 52, 83, 84, 85, 104
 - CPT 90632 through 90634, 90636, 90730 (old code)
- **Rotavirus**
 - Immunization (CVX) codes 74, 116, 119, 122
 - CPT 90680
- **Influenza**
 - Immunization (CVX) codes 15, 16, 88, 111, 135, 140, 141, 144, 149, 150, 151, 153, 155, 158, 161, 166
 - CPT 90630, 90654 through 90658, 90659 (old code), 90660 through 90662, 90672, 90673, 90685 through 90688, 90724 (old code), G0008, G8108 (old code)

Immunization Definitions

- **DTaP IZ Definitions**
 - Immunization (CVX) codes 20, 50, 102, 106, 107, 110, 120, 130, 132, 146
 - POV ICD-9: V06.1
 - CPT 90696, 90698, 90700, 90721, 90723
- **DTaP Contraindication Definition**
 - Immunization Package contraindication of “Anaphylaxis”
- **DTP IZ Definitions**

- Immunization (CVX) codes 1, 22, 102
- POV ICD-9: V06.1, V06.2, V06.3
- CPT 90701, 90711 (old code), 90720
- **DTP Contraindication Definition**
 - Immunization Package contraindication of “Anaphylaxis”
- **Tdap IZ Definitions**
 - Immunization (CVX) code 115
 - CPT 90715
- **Tdap contraindication definition**
 - Immunization Package contraindication of “Anaphylaxis”
- **DT IZ Definitions**
 - Immunization (CVX) code 28
 - POV ICD-9: V06.5
 - CPT 90702
- **DT Contraindication Definition**
 - Immunization Package contraindication of “Anaphylaxis”
- **Td IZ Definitions**
 - Immunization (CVX) codes 9, 113, 138, 139
 - POV ICD-9: V06.5
 - CPT 90714, 90718
- **Td Contraindication Definition**
 - Immunization Package contraindication of “Anaphylaxis”
- **Diphtheria IZ Definitions**
 - POV ICD-9: V03.5
 - CPT 90719
- **Diphtheria Contraindication Definition**
 - Immunization Package contraindication of “Anaphylaxis”
- **Tetanus Definitions**
 - Immunization (CVX) codes 35, 112
 - POV ICD-9: V03.7
 - CPT 90703
- **Tetanus Contraindication Definition**
 - Immunization Package contraindication of “Anaphylaxis”

- **Acellular Pertussis Definitions**
 - Immunization (CVX) code 11
 - POV ICD-9: V03.6
- **Acellular Pertussis Contraindication Definition**
 - Immunization Package contraindication of “Anaphylaxis”
- **OPV Definitions**
 - Immunization (CVX) codes 2, 89
 - CPT 90712
- **OPV Contraindication Definition**
 - Immunization Package contraindication of “Immune Deficiency”
- **IPV Definitions**
 - Immunization (CVX) codes 10, 89, 110, 120, 130, 132, 146
 - POV ICD-9: V04.0, V06.3
 - CPT 90696, 90698, 90711 (old code), 90713, 90723
- **IPV Evidence of Disease Definitions**
 - POV or PCC Problem List (active or inactive) ICD-9: 730.70 through 730.79; ICD-10: M89.6*
- **IPV contraindication definition:**
 - Immunization Package contraindication of “Anaphylaxis” or “Neomycin Allergy”
- **MMR Definitions**
 - Immunization (CVX) codes 3, 94
 - POV ICD-9: V06.4
 - CPT 90707, 90710
- **MMR Contraindication Definitions**
 - Immunization Package contraindication of “Anaphylaxis”, “Immune Deficiency”, or “Neomycin Allergy”
- **M/R Definitions**
 - Immunization (CVX) code 4
 - CPT 90708
- **M/R Contraindication Definition**
 - Immunization Package contraindication of “Anaphylaxis”
- **R/M Definitions**
 - Immunization (CVX) code 38

- CPT 90709 (old code)
- **R/M Contraindication Definition**
 - Immunization Package contraindication of “Anaphylaxis”
- **Measles Definitions**
 - Immunization (CVX) code 5
 - POV ICD-9: V04.2
 - CPT 90705
- **Measles Evidence of Disease Definition**
 - POV or PCC Problem List (active or inactive) ICD-9: 055*; ICD-10: B05.*
- **Measles Contraindication Definition**
 - Immunization Package contraindication of “Anaphylaxis”
- **Mumps Definitions**
 - Immunization (CVX) code 7
 - POV ICD-9: V04.6
 - CPT 90704
- **Mumps Evidence of Disease Definition**
 - POV or PCC Problem List (active or inactive) ICD-9: 072*; ICD-10: B26.*
- **Mumps Contraindication Definition**
 - Immunization Package contraindication of “Anaphylaxis”
- **Rubella Definitions**
 - Immunization (CVX) code 6
 - POV ICD-9: V04.3
 - CPT 90706
- **Rubella Evidence of Disease Definitions**
 - POV or PCC Problem List (active or inactive) ICD-9: 056*, 771.0; ICD-10: B06.*
- **Rubella Contraindication Definition**
 - Immunization Package contraindication of “Anaphylaxis”
- **HiB Definitions**
 - Three-dose series:
 - Immunization (CVX) codes 49, 51
 - CPT 90647, 90748

- Four-dose series:
 - Immunization (CVX) codes 17, 22, 46 through 48, 50, 102, 120, 132, 146
 - POV ICD-9: V03.81
 - CPT 90645 through 90646, 90648, 90698, 90720 through 90721, 90737 (old code)
- **HiB Contraindication Definition**
 - Immunization Package contraindication of “Anaphylaxis”
- **Hepatitis B Definitions**
 - Immunization (CVX) codes 8, 42 through 45, 51, 102, 104, 110, 132, 146
 - CPT 90636, 90723, 90731 (old code), 90740, 90743 through 90748, G0010, Q3021 (old code), Q3023 (old code)
- **Hepatitis B Evidence of Disease Definitions**
 - POV or PCC Problem List (active or inactive) ICD-9: V02.61, 070.2*, 070.3*; ICD-10: B16.*, B19.1*, Z22.51
- **Hepatitis B contraindication definition**
 - Immunization Package contraindication of “Anaphylaxis”
- **Varicella Definitions**
 - Immunization (CVX) codes 21, 94
 - POV ICD-9: V05.4
 - CPT 90710, 90716
- **Varicella Evidence of Disease Definitions**
 - POV or PCC Problem List (active or inactive) ICD-9: 052*, 053*; ICD-10: B01.* through B02.*
 - Immunization Package contraindication of “Hx of Chicken Pox” or “Immune”
- **Varicella Contraindication Definitions**
 - Immunization Package contraindication of “Anaphylaxis”, “Immune Deficiency”, or “Neomycin Allergy”
- **Pneumococcal Definitions**
 - Immunization (CVX) codes 33, 100, 109, 133, 152
 - POV ICD-9: V06.6, V03.82
 - CPT 90669, 90670, 90732, G0009, G8115 (old code), G9279
- **Pneumococcal Contraindication Definition**

- Immunization Package contraindication of “Anaphylaxis”
- **Hepatitis A Definitions**
 - Immunization (CVX) codes 31, 52, 83, 84, 85, 104
 - CPT 90632 through 90634, 90636, 90730 (old code)
- **Hepatitis A Evidence of Disease Definitions**
 - POV or PCC Problem List (active or inactive) ICD-9: 070.0, 070.1; ICD-10: B15.*
- **Hepatitis A Contraindication Definition**
 - Immunization Package contraindication of "Anaphylaxis"
- **Rotavirus Definitions**
 - 2-dose series
 - Immunization (CVX) codes 119
 - CPT 90681
 - 3-dose series
 - Immunization (CVX) codes 74, 116, 122
 - POV ICD-9: V05.8
 - CPT 90680
- **Rotavirus Contraindication Definition**
 - Immunization Package contraindication of "Anaphylaxis" or "Immune Deficiency"
- **Influenza Definitions**
 - Immunizations (CVX) codes 15, 16, 88, 111, 135, 140, 141, 144, 149, 150, 151, 153, 155, 158, 161, 166
 - POV ICD-9: V04.8 (old code), V04.81, V06.6
 - CPT 90630, 90654 through 90658, 90659 (old code), 90660 through 90662, 90672, 90673, 90685 through 90688, 90724 (old code), G0008, G8108 (old code)
- **Influenza Contraindication Definition**
 - Immunization Package contraindication of "Egg Allergy" or "Anaphylaxis"

2.3.3.6 GPRA 2016 Description

During GPRA Year 2016, achieve the target rate of 76.8% for the proportion of AI/AN children ages 19 through 35 months who have received the recommended immunizations.

Notes: In FY 2013, the GPRA measure changed to the 4:3:1:3*:3:1:4 combination, which includes three or four HiB.

In FY 2011, the GPRA measure changed to the 4:3:1:3:3:1:4 combination, which includes pneumococcal.

2.3.3.7 Patient List

List of patients 19 through 35 months of age with IZ, if any. If a patient did not have all doses in a multiple dose vaccine, the IZ will not be listed. For example, if a patient only had two DTaP, no IZ will be listed for DTaP.

Note: Because age is calculated at the beginning of the Report Period, the patient's age on the list will be between 7 and 23 months

2.3.4 Adolescent Immunizations

2.3.4.1 Owner and Contact

Epidemiology Program: Dr. Scott Hamstra, Amy Groom, MPH

2.3.4.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; not reported to OMB and Congress)

2.3.4.3 Denominators

1. Active Clinical patients age 13 years.
2. Male Active Clinical patients age 13 years.
3. Female Active Clinical patients age 13 years.
4. Active Clinical patients ages 13 through 17 years.
5. Male Active Clinical patients ages 13 through 17 years.

6. Female Active Clinical patients ages 13 through 17 years.

2.3.4.4 Numerators

1. Patients who have received the 1:1:3 combination (i.e., one Tdap or Td, one Meningococcal, three HPV), including contraindications.

Note: The only refusals included in this numerator are NMI refusals.

- A. Patients with (1) a contraindication or (2) a documented NMI refusal.
2. Patients who have received the 1:1 combination (i.e., one Tdap or Td, one Meningococcal), including contraindications.

Note: The only refusals included in this numerator are NMI refusals.

- A. Patients with (1) a contraindication or (2) a documented NMI refusal.
3. Patients who have received one dose of Tdap or Td ever, including contraindications.

Note: The only refusals included in this numerator are NMI refusals.

- A. Patients with (1) a contraindication or (2) a documented NMI refusal.
- B. Patients who have received one dose of Tdap ever, including contraindications.

Note: The only refusals included in this numerator are NMI refusals.

4. Patients who have received one dose of meningococcal ever, including contraindications.

Note: The only refusals included in this numerator are NMI refusals.

- A. Patients with (1) a contraindication or (2) a documented NMI refusal.
5. Patients who have received three doses of HPV ever, including contraindications.

Note: The only refusals included in this numerator are NMI refusals.

- A. Patients with (1) a contraindication or (2) a documented NMI refusal.

2.3.4.5 Definitions

Timing of Doses

Because IZ data comes from multiple sources, any IZ codes documented on dates within 10 days of each other will be considered as the same immunization.

Dosage and Types of Immunizations

- One dose of Td or Tdap
- One dose of Meningococcal
- Three doses of HPV

Not Medically Indicated (NMI) Refusal and Contraindication Information

Not Medically Indicated refusals and contraindications for individual immunizations will also count toward meeting the definition, as defined in the following subsections.

Note: NMI refusals are not counted as refusals; rather, they are counted as contraindications.

- For immunizations where required number of doses is greater than one, only one NMI refusal is necessary to be counted in the numerator. For example, if there is a single NMI refusal for Hepatitis B, the patient will be included in the numerator.
- For immunizations where required number of doses is greater than one, only one contraindication is necessary to be counted in the numerator. For example, if there is a single contraindication for HiB, the patient will be included in the numerator.

NMI Refusal Definitions

PCC Refusal type NMI for any of the following codes:

- **Tdap**
 - Immunization (CVX) codes 115
 - CPT 90715
- **Td**
 - Immunization (CVX) codes 9, 113
 - CPT 90714, 90718
- **Meningococcal**

- Immunization (CVX) codes 32, 108, 114, 136, 147
- CPT 90733, 90734
- **HPV**
 - Immunization (CVX) codes 62, 118, 137, 165
 - CPT 90649, 90650, 90651

Immunization Definitions

- **Tdap**
 - Immunization (CVX) code 115
 - CPT 90715
- **Tdap Contraindication Definition**
 - Immunization Package contraindication of “Anaphylaxis”
- **Td**
 - Immunization (CVX) code 9, 113, 138, 139
 - POV ICD-9: V06.5
 - CPT 90714, 90718
- **Td Contraindication Definition**
 - Immunization Package contraindication of “Anaphylaxis”
- **Meningococcal**
 - Immunization (CVX) codes: 32, 108, 114, 136, 147
 - CPT 90733, 90734
- **Meningococcal Contraindication Definition**
 - Immunization Package contraindication of “Anaphylaxis”
- **HPV**
 - Immunization (CVX) codes: 62, 118, 137, 165
 - CPT 90649, 90650, 90651
- **HPV Contraindication Definition**
 - Immunization Package contraindication of “Anaphylaxis”

2.3.4.6 Patient List

List of patients 13 through 17 years of age with IZ, if any. If a patient did not have all doses in a multiple dose vaccine, the IZ will not be listed. For example, if a patient only had two HPV, no IZ will be listed for HPV.

2.4 Childhood Diseases Group

2.4.1 Appropriate Treatment for Children with Upper Respiratory Infection

2.4.1.1 Owner and Contact

Dr. Scott Hamstra

2.4.1.2 National Reporting

Not reported nationally

2.4.1.3 Denominators

1. Active Clinical patients who were ages 3 months through 18 years who were diagnosed with an upper respiratory infection during the period 6 months (182 days) prior to the Report Period through the first 6 months of the Report Period.

2.4.1.4 Numerators

1. Patients who were *not* prescribed an antibiotic on or within 3 days after diagnosis. In this measure, appropriate treatment is not to receive an antibiotic.

2.4.1.5 Definitions

Age

Age is calculated as follows: Children 3 months as of 6 months (182 days) of the year prior to the Report Period to 18 years as of the first 6 months of the Report Period.

Upper Respiratory Infection

- POV ICD-9: 460, 465.*; ICD-10: J00

Outpatient Visit

- Service Category A, S, O

Antibiotic Medications:

- Medication taxonomy BGP HEDIS ANTIBIOTIC MEDS.
 - Medications are: Amoxicillin, Amoxicillin and Clavulanate, Ampicillin, Azithromycin, Cefaclor, Cefadroxil, Cefazolin, Cefdinir, Cefditoren, Cefixime, Cefpodoxime, Cefprozil, Ceftibuten, Ceftriaxone, Cefuroxime, Cephalexin, Ciprofloxacin, Clarithromycin, Clindamycin, Dicloxacillin, Doxycycline, Erythromycin, Erythromycin ethylsuccinate, Erythromycin

lactobionate, Erythromycin stearate, Erythromycin-sulfisoxazole, Levofloxacin, Minocycline, Moxifloxacin, Ofloxacin, Penicillin VK, Penicillin G, Sulfisoxazole, Tetracycline, Trimethoprim. Medications must not have a comment of RETURNED TO STOCK.

- Procedure ICD-9: 99.21; ICD-10: 3E00X29, 3E01329, 3E02329, 3E03029, 3E03329, 3E04029, 3E04329, 3E05029, 3E05329, 3E06029, 3E06329, 3E0E329, 3E0E729, 3E0E829, 3E0F329, 3E0F729, 3E0F829, 3E0G329, 3E0G729, 3E0G829, 3E0H329, 3E0H729, 3E0H829, 3E0J329, 3E0J729, 3E0J829, 3E0K329, 3E0K729, 3E0K829, 3E0L329, 3E0M329, 3E0N329, 3E0N729, 3E0N829, 3E0P329, 3E0P729, 3E0P829, 3E0Q329, 3E0R329, 3E0S329, 3E0U029, 3E0U329, 3E0V329, 3E0W329, 3E0Y329
- To be included in the denominator *all* of the following conditions must be met:
 - Patient’s diagnosis of an upper respiratory infection (URI) must have occurred at an outpatient visit.
 - If outpatient visit was to Clinic code 30 (Emergency Medicine), it must not have resulted in a hospitalization, defined as Service Category H, either on the same day or the next day with URI diagnosis.
 - Patient’s visit must *only* have a diagnosis of URI. If any other diagnosis exists, the visit will be excluded.
 - The patient did not have a new or refill prescription (Rx) for antibiotics within 30 days prior to the URI visit date.
 - The patient did not have an active prescription for antibiotics as of the URI visit date. “Active” prescription defined as:
 - Rx Days’ Supply must be greater than or equal to the URI Visit Date minus the Rx Date

If there are multiple visits that meet the criteria, the first visit will be used.

2.4.1.6 Patient List

List of patients 3 months to 18 years with upper respiratory infection, with antibiotic prescription, if any.

2.4.2 Appropriate Testing for Children with Pharyngitis

2.4.2.1 Owner and Contact

Dr. Scott Hamstra

2.4.2.2 National Reporting

Not reported nationally

2.4.2.3 Denominators

1. Active Clinical patients who were ages 3 through 18 years who were diagnosed with pharyngitis and prescribed an antibiotic during the period 6 months (182 days) prior to the Report Period through the first 6 months of the Report Period.

2.4.2.4 Numerators

1. Patients who received a Group A strep test.

2.4.2.5 Definitions**Age**

Age is calculated as follows: Children 3 years as of 6 months (182 days) of the year prior to the Report Period to 18 years as of the first 6 months of the Report Period.

Pharyngitis

- POV ICD-9: 462, 463, 034.0; ICD-10: J02.0, J03.*

Outpatient Visit

- Service Category A, S, O

Antibiotic Medications

- Medication taxonomy BGP HEDIS ANTIBIOTIC MEDS
 - Medications are: Amoxicillin, Amoxicillin and Clavulanate, Ampicillin, Azithromycin, Cefaclor, Cefadroxil, Cefazolin, Cefdinir, Cefixime, Cefditoren, Ceftibuten, Cefpodoxime, Cefprozil, Ceftriaxone, Cefuroxime, Cephalexin, Ciprofloxacin, Clarithromycin, Clindamycin, Dicloxacillin, Doxycycline, Erythromycin, Erythromycin ethylsuccinate, Erythromycin lactobionate, Erythromycin stearate, Erythromycin-sulfisoxazole, Levofloxacin, Minocycline, Moxifloxacin, Ofloxacin, Penicillin VK, Penicillin G, Sulfisoxazole, Tetracycline, Trimethoprim. Medications must not have a comment of RETURNED TO STOCK.
- Procedure ICD-9: 99.21; ICD-10: 3E00X29, 3E01329, 3E02329, 3E03029, 3E03329, 3E04029, 3E04329, 3E05029, 3E05329, 3E06029, 3E06329, 3E0E329, 3E0E729, 3E0E829, 3E0F329, 3E0F729, 3E0F829, 3E0G329, 3E0G729, 3E0G829, 3E0H329, 3E0H729, 3E0H829, 3E0J329, 3E0J729, 3E0J829, 3E0K329, 3E0K729, 3E0K829, 3E0L329, 3E0M329, 3E0N329,

3E0N729, 3E0N829, 3E0P329, 3E0P729, 3E0P829, 3E0Q329, 3E0R329,
3E0S329, 3E0U029, 3E0U329, 3E0V329, 3E0W329, 3E0Y329

Group A Streptococcus Test

- CPT 87430 (by enzyme immunoassay), 87650 through 87652 (by nucleic acid), 87880 (by direct optical observation), 87081 (by throat culture), 3210F (Group A Strep Test)
- Site-populated taxonomy BGP GROUP A STREP
- LOINC taxonomy

To be included in the denominator *all* of the following conditions must be met:

- Patient's diagnosis of pharyngitis must have occurred at an outpatient visit.
- If outpatient visit was to Clinic code 30 (Emergency Medicine), it must not have resulted in a hospitalization, defined as service category H, either on the same day or the next day with pharyngitis diagnosis.
- Patient's visit must *only* have a diagnosis of pharyngitis. If any other diagnosis exists, the visit will be excluded.
- The patient did not have a new or refill prescription for antibiotics within 30 days prior to the pharyngitis visit date.
- The patient did not have an active prescription for antibiotics as of the pharyngitis visit date. "Active" prescription defined as:
- Rx Days' Supply must be greater than or equal to the URI Visit Date minus the Rx Date
- The patient filled a prescription for antibiotics on or within three days after the pharyngitis visit.

If there are multiple visits that meet the criteria, the first visit will be used.

- **To be included in the numerator**
 - A patient must have received a Group A Streptococcus test within the 7-day period beginning three days prior through three days after the Pharyngitis visit date.

2.4.2.6 Patient List

List of patients 3 through 18 years of age with pharyngitis and a Group A Strep test, if any.

2.5 Cancer Screen Group

2.5.1 Cancer Screening: Pap Smear Rates

2.5.1.1 Owner and Contact

Carolyn Aoyama, CNM, MPH

2.5.1.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.5.1.3 Denominators

1. GPRA: Female Active Clinical patients ages 24 through 64 years without a documented history of hysterectomy. Patients must be at least 24 years of age at the beginning of the Report Period and less than 65 years of age as of the end of the Report Period.
2. Female Active Clinical patients ages 24 through 29 without documented history of hysterectomy.
3. Female Active Clinical patients ages 30 through 64 without documented history of hysterectomy.
4. Female User Population patients ages 24 through 64 years without a documented history of hysterectomy.
5. Female User Population patients ages 24 through 29 without documented history of hysterectomy.
6. Female User Population patients ages 30 through 64 without documented history of hysterectomy.

2.5.1.4 Numerators

1. GPRA: Patients with documented Pap smear in past 3 years, or if patient is 30 to 64 years of age, either a Pap Smear documented in the past 3 years or a Pap Smear and an HPV DNA documented in the past 5 years.

Note: This numerator does *not* include refusals.

2. Patients with a Pap Smear documented in the past 3 years.

Note: This numerator does *not* include refusals.

3. Patients with a Pap Smear documented 3 to 5 years ago and an HPV DNA documented in the past 5 years.

Note: This numerator does *not* include refusals.

2.5.1.5 Definitions

Age

Age of the patient is calculated at the beginning of the Report Period. Patients must be at least 24 years of age at the beginning of the Report Period and less than 65 years of age as of the end of the Report Period.

Hysterectomy

Defined as any of the following ever:

- Procedure ICD-9: 68.4 through 68.9; ICD-10: 0UT9*ZZ
- CPT 51925, 56308 (old code), 58150, 57540, 57545, 57550, 57555, 57556, 58152, 58200 through 58294, 58548, 58550 through 58554, 58570 through 58573, 58951, 58953 through 58954, 58956, 59135
- Diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 618.5, 752.43, V88.01, V88.03; ICD-10: N99.3, Z12.72, Z90.710 through Z90.712, Q51.5
- Women's Health procedure called Hysterectomy

Pap Smear

- Lab Pap Smear
- POV ICD-9: V76.2 Screen Mal Neop-Cervix, V72.32 Encounter for Pap Cervical Smear to Confirm Findings of Recent Normal Smear Following Initial Abnormal Smear, 795.0*; ICD-10: R87.61*, R87.810, R87.820, Z01.42, Z12.4
- CPT 88141 through 88154, 88160 through 88167, 88174 through 88175, G0123, G0124, G0141, G0143 through G0145, G0147, G0148, P3000, P3001, Q0091
- Women's Health procedure called Pap Smear and where the result does NOT have "ERROR/DISREGARD"
- LOINC taxonomy
- Site-populated taxonomy BGP PAP SMEAR TAX

HPV DNA

Note: CRS will only search for a documented HPV DNA if the patient had a Pap Smear 3 to 5 years ago.

- Lab HPV
- POV ICD-9: V73.81, 079.4, 796.75, 795.05, 795.15, 796.79, 795.09, 795.19; ICD-10: B97.7, R85.618, R85.81, R85.82, R87.628, R87.810, R87.811, R87.820, R87.821, Z11.51
- CPT 87620 through 87622 (old codes), 87623 through 87625
- Women's Health procedure called HPV Screen and where the result does NOT have "ERROR/DISREGARD"
- Women's Health procedure called Pap Smear and where the HPV field equals Yes
- LOINC taxonomy
- Site-populated taxonomy BGP HPV TAX

2.5.1.6 GPRA 2016 Description

During GPRA Year 2016, achieve the target rate of 55.6% for the proportion of female patients ages 24 through 64 years without a documented history of hysterectomy who have had a Pap screen within the previous 3 years, or if the patient is over 30, had a Pap screen in the past 3 years or a Pap screen and HPV DNA within the previous 5 years.

2.5.1.7 Patient List

List of women 24 through 64 years of age with documented Pap smear, if any.

2.5.2 Cancer Screening: Mammogram Rates**2.5.2.1 Owner and Contact**

Carolyn Aoyama, CNM, MPH

2.5.2.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.5.2.3 Denominators

1. **GPRAs:** Female Active Clinical patients ages 52 through 64 years, without a documented bilateral mastectomy or two separate unilateral mastectomies.
2. Female User Population patients ages 52 through 64 years, without a documented bilateral mastectomy or two separate unilateral mastectomies.

2.5.2.4 Numerators

1. **GPRAs:** Patients with documented mammogram in past 2 years.

Note: This numerator does *not* include refusals.

2. Patients with documented mammogram refusal in past year.

2.5.2.5 Definitions

Age

Age of the patient is calculated at the beginning of the Report Period. For all denominators, patients must be at least the minimum age as of the beginning of the Report Period. For the 52 through 64 years of age denominator, the patients must be less than 65 years of age as of the end of the Report Period.

Bilateral Mastectomy

- CPT 19300.50 through 19307.50 *or* 19300 through 19307 with modifier 09950 (50 and 09950 modifiers indicate bilateral), or old codes 19180, 19200, 19220, or 19240, with modifier of 50 or 09950 *or*
- Procedure ICD-9: 85.42, 85.44, 85.46, 85.48; ICD-10: 0HBV0ZZ, 0HCV0ZZ, 0HTV0ZZ
- POV ICD-10: Z90.13

Two Separate Unilateral Mastectomies

Requires either of the following:

- Must have one code that indicates a right mastectomy and one code that indicates a left mastectomy
- Must have 2 separate occurrences on 2 different dates of service for one code that indicates a mastectomy on unknown side and one code that indicates either a right or left mastectomy, or two codes that indicate a mastectomy on unknown side

Right Mastectomy

- POV ICD-10: Z90.11

- Procedure ICD-10: 07T50ZZ, 07T80ZZ, 0HBT0ZZ, 0HCT0ZZ, 0HTT0ZZ

Left Mastectomy

- POV ICD-10: Z90.12
- Procedure ICD-10: 07T60ZZ, 07T90ZZ, 0HBU0ZZ, 0HCU0ZZ, 0HTU0ZZ

Mastectomy on Unknown Side

- CPT 19300 through 19307, or old codes 19180, 19200, 19220, 19240 or
- Procedure ICD-9: 85.41, 85.43, 85.45, 85.47

Mammogram

- Radiology or CPT 77052 through 77059, 76090 (old code), 76092 (old code), G0206, G0204, G0202
- POV ICD-9: V76.11 screening mammogram for high risk patient, V76.12 other screening mammogram, 793.80 Abnormal mammogram, unspecified, 793.81 Mammographic microcalcification, 793.89 Other abnormal findings on radiological exam of breast; ICD-10: R92.0, R92.1, R92.8, Z12.31
- Procedure ICD-9: 87.36 Xerography of breast, 87.37 Other Mammography; ICD-10: BH00ZZZ, BH01ZZZ, BH02ZZZ
- Women's Health procedure called Mammogram Screening, Mammogram Diagnosis Bilateral, Mammogram Diagnosis Unilateral, and where the mammogram result does *not* have "ERROR/DISREGARD"

Refusal Mammogram

Any of the following in the past year:

- Radiology MAMMOGRAM for CPT 77052 through 77059, 76090 (old code), 76091 (old code), 76092 (old code), G0206, G0204, G0202

2.5.2.6 GPRA 2016 Description

During GPRA Year 2016, achieve the target rate of 55.9% for the proportion of female patients ages 52 through 64 years who have had mammography screening within the last 2 years.

2.5.2.7 Patient List

List of women 52 through 74 with mammogram or refusal, if any.

2.5.3 Colorectal Cancer Screening

Notes: Based on the HEDIS definition which has lowered the upper age from 80 to 75 years.

Numerator does not include Double Contrast Barium Enema (DCBE).

2.5.3.1 Owner: Contact

Epidemiology Program: Don Haverkamp

2.5.3.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.5.3.3 Denominators

1. GPRA: Active Clinical patients ages 50 through 75 years without a documented history of colorectal cancer or total colectomy. Broken down by gender.

Note: Since HEDIS calculates age at the end of the Report Period, the patient's at the beginning of the Report Period must be at least 50 years of age and 51 years of age at the end of the Report Period.

2. User Population patients ages 50 through 75 years without a documented history of colorectal cancer or total colectomy. Broken down by gender.

2.5.3.4 Numerators

1. GPRA: Patients who have had any Colorectal Cancer (CRC) screening, defined as any of the following:
 - A. Fecal Occult Blood Test (FOBT) or FIT during the Report Period
 - B. Flexible sigmoidoscopy in the past 5 years
 - C. Colonoscopy in the past 10 years
2. Patients with documented CRC screening refusal in the past year.
3. Patients with Fecal Occult Blood test (FOBT) or Fecal Immunochemical Test (FIT) during the Report Period.
4. Patients with a flexible sigmoidoscopy in the past 5 years or a colonoscopy in the past 10 years.

2.5.3.5 Definitions

Denominator Exclusions

Any diagnosis ever of one of the following:

- Colorectal Cancer
 - POV ICD-9: 153.*, 154.0, 154.1, 197.5, V10.05; ICD-10: C18.*, C19, C20, C78.5, Z85.030, Z85.038
 - CPT G0213 through G0215 (old codes), G0231 (old code)
- Total Colectomy
 - CPT 44150 through 44151, 44152 (old code), 44153 (old code), 44155 through 44158, 44210 through 44212
 - Procedure ICD-9: 45.8*; ICD-10: 0DTE*ZZ

Colorectal Cancer Screening

The most recent of any of the following during applicable timeframes:

- FOBT or FIT
 - CPT 82270, 82274, 89205 (old code), G0107 (old code), G0328, G0394 (old code)
 - LOINC taxonomy
 - Site-populated taxonomy BGP GPRA FOB TESTS
- Flexible Sigmoidoscopy
 - Procedure ICD-9: 45.24; ICD-10: 0DJD8ZZ
 - CPT 45330 through 45345, G0104
- Colonoscopy
 - Procedure ICD-9: 45.22, 45.23, 45.25, 45.42, 45.43; ICD-10: 0D5E4ZZ, 0D5E8ZZ, 0D5F4ZZ, 0D5F8ZZ, 0D5G4ZZ, 0D5G8ZZ, 0D5H4ZZ, 0D5H8ZZ, 0D5K4ZZ, 0D5K8ZZ, 0D5L4ZZ, 0D5L8ZZ, 0D5M4ZZ, 0D5M8ZZ, 0D5N4ZZ, 0D5N8ZZ, 0D9E3ZX, 0D9E4ZX, 0D9E7ZX, 0D9E8ZX, 0D9F3ZX, 0D9F4ZX, 0D9F7ZX, 0D9F8ZX, 0D9G3ZX, 0D9G4ZX, 0D9G7ZX, 0D9G8ZX, 0D9H3ZX, 0D9H4ZX, 0D9H7ZX, 0D9H8ZX, 0D9K3ZX, 0D9K4ZX, 0D9K7ZX, 0D9K8ZX, 0D9L3ZX, 0D9L4ZX, 0D9L7ZX, 0D9L8ZX, 0D9M3ZX, 0D9M4ZX, 0D9M7ZX, 0D9M8ZX, 0D9N3ZX, 0D9N4ZX, 0D9N7ZX, 0D9N8ZX, 0DBE3ZX, 0DBE4ZX, 0DBE7ZX, 0DBE8ZX, 0DBE8ZZ, 0DBF3ZX, 0DBF4ZX, 0DBF7ZX, 0DBF8ZX, 0DBF8ZZ, 0DBG3ZX, 0DBG4ZX, 0DBG7ZX, 0DBG8ZX, 0DBG8ZZ, 0DBH3ZX, 0DBH4ZX, 0DBH7ZX, 0DBH8ZX, 0DBH8ZZ, 0DBK3ZX, 0DBK4ZX, 0DBK7ZX, 0DBK8ZX, 0DBK8ZZ, 0DBL3ZX, 0DBL4ZX, 0DBL7ZX, 0DBL8ZX, 0DBL8ZZ, 0DBM3ZX,

0DBM4ZX, 0DBM7ZX, 0DBM8ZX, 0DBM8ZZ, 0DBN3ZX, 0DBN4ZX,
0DBN7ZX, 0DBN8ZX, 0DBN8ZZ, 0DJD8ZZ

- CPT 44388 through 44394, 44397, 45355, 45378 through 45387, 45391, 45392, G0105, G0121, G9252, G9253

Screening Refusals in Past Year

- FOBT or FIT

Refusal of any of the following:

- Lab Fecal Occult Blood test
- CPT code 82270, 82274, 89205 (old code), G0107 (old code), G0328, G0394 (old code)

- Flexible Sigmoidoscopy

Refusal of any of the following:

- Procedure ICD-9: 45.24; ICD-10: 0DJD8ZZ
- CPT 45330 through 45345, G0104

- Colonoscopy

Refusal of any of the following:

- Procedure ICD-9: 45.22, 45.23, 45.25, 45.42, 45.43; 0D5E4ZZ, 0D5E8ZZ, 0D5F4ZZ, 0D5F8ZZ, 0D5G4ZZ, 0D5G8ZZ, 0D5H4ZZ, 0D5H8ZZ, 0D5K4ZZ, 0D5K8ZZ, 0D5L4ZZ, 0D5L8ZZ, 0D5M4ZZ, 0D5M8ZZ, 0D5N4ZZ, 0D5N8ZZ, 0D9E3ZX, 0D9E4ZX, 0D9E7ZX, 0D9E8ZX, 0D9F3ZX, 0D9F4ZX, 0D9F7ZX, 0D9F8ZX, 0D9G3ZX, 0D9G4ZX, 0D9G7ZX, 0D9G8ZX, 0D9H3ZX, 0D9H4ZX, 0D9H7ZX, 0D9H8ZX, 0D9K3ZX, 0D9K4ZX, 0D9K7ZX, 0D9K8ZX, 0D9L3ZX, 0D9L4ZX, 0D9L7ZX, 0D9L8ZX, 0D9M3ZX, 0D9M4ZX, 0D9M7ZX, 0D9M8ZX, 0D9N3ZX, 0D9N4ZX, 0D9N7ZX, 0D9N8ZX, 0DBE3ZX, 0DBE4ZX, 0DBE7ZX, 0DBE8ZX, 0DBE8ZZ, 0DBF3ZX, 0DBF4ZX, 0DBF7ZX, 0DBF8ZX, 0DBF8ZZ, 0DBG3ZX, 0DBG4ZX, 0DBG7ZX, 0DBG8ZX, 0DBG8ZZ, 0DBH3ZX, 0DBH4ZX, 0DBH7ZX, 0DBH8ZX, 0DBH8ZZ, 0DBK3ZX, 0DBK4ZX, 0DBK7ZX, 0DBK8ZX, 0DBK8ZZ, 0DBL3ZX, 0DBL4ZX, 0DBL7ZX, 0DBL8ZX, 0DBL8ZZ, 0DBM3ZX, 0DBM4ZX, 0DBM7ZX, 0DBM8ZX, 0DBM8ZZ, 0DBN3ZX, 0DBN4ZX, 0DBN7ZX, 0DBN8ZX, 0DBN8ZZ, 0DJD8ZZ
- CPT 44388 through 44394, 44397, 45355, 45378 through 45387, 45391, 45392, G0105, G0121, G9252, G9253

2.5.3.6 GPRA 2016 Description

During GPRA Year 2016, achieve the target rate of 38.7% for the proportion of clinically appropriate patients ages 50 through 75 who have received colorectal screening.

2.5.3.7 Patient List

List of patients 50 through 75 with CRC screening or refusal, if any.

2.5.4 Comprehensive Cancer Screening

2.5.4.1 Owner and Contact

Epidemiology Program: Don Haverkamp, Carolyn Aoyama

2.5.4.2 National Reporting

NATIONAL (included in IHS Performance Report; *not* reported to OMB and Congress)

2.5.4.3 Denominators

1. GPRA Developmental: Active Clinical patients ages 24 through 75 years who are eligible for cervical cancer, breast cancer, or colorectal cancer screening.
 - A. Active Clinical female patients ages 24 through 75 years.
 - B. Active Clinical male patients ages 50 through 75 years.

2.5.4.4 Numerators

1. GPRA Developmental: Patients who have had all screenings for which they are eligible.
2. Female patients with cervical cancer, breast cancer, or colorectal cancer screening.
3. Male patients with colorectal cancer screening.

2.5.4.5 Definitions

Cervical Cancer Screening

To be eligible for this screening:

- Patients must be female Active Clinical ages 24 years 64 and not have a documented history of hysterectomy.

- Patients must be at least 24 years of age at the beginning of the Report Period and less than 65 years of age as of the end of the Report Period.
- To be counted as having the screening, the patient must have had a Pap Smear documented in the past 3 years, or if the patient is 30 to 64 years of age, either a Pap Smear documented in the past 3 years or a Pap Smear and an HPV DNA documented in the past 5 years.

Hysterectomy

Any of the following ever:

- Procedure ICD-9: 68.4 through 68.9; ICD-10: 0UT9*ZZ
- CPT 51925, 56308 (old code), 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200 through 58294, 58548, 58550 through 58554, 58570 through 58573, 58951, 58953 through 58954, 58956, 59135
- Diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 618.5, 752.43, V88.01, V88.03; ICD-10: N99.3, Z12.72, Z90.710 through Z90.712, Q51.5
- Women's Health procedure called Hysterectomy

Pap Smear

- Lab Pap Smear
- POV ICD-9: V76.2 Screen Mal Neop-Cervix, V72.32 Encounter for Pap Cervical Smear to Confirm Findings of Recent Normal Smear Following Initial Abnormal Smear, 795.0*; ICD-10: R87.61*, R87.810, R87.820, Z01.42, Z12.4
- CPT 88141 through 88154, 88160 through 88167, 88174 through 88175, G0123, G0124, G0141, G0143 through G0145, G0147, G0148, P3000, P3001, Q0091
- Women's Health procedure called Pap Smear and where the result does NOT have "ERROR/DISREGARD"
- LOINC taxonomy
- Site-populated taxonomy BGP PAP SMEAR TAX

HPV DNA

Note: CRS will only search for a documented HPV DNA if the patient had a Pap Smear 3 to 5 years ago.

- Lab HPV

- POV ICD-9: V73.81, 079.4, 796.75, 795.05, 795.15, 796.79, 795.09, 795.19; ICD-10: B97.7, R85.618, R85.81, R85.82, R87.628, R87.810, R87.811, R87.820, R87.821, Z11.51
- CPT 87620 through 87622 (old codes), 87623 through 87625
- Women's Health procedure called HPV Screen and where the result does NOT have "ERROR/DISREGARD"
- Women's Health procedure called Pap Smear and where the HPV field equals Yes
- LOINC taxonomy
- Site-populated taxonomy BGP HPV TAX

Breast Cancer Screening

To be eligible for this screening

- Patients must be female Active Clinical ages 52 through 64 years and not have a documented history ever of bilateral mastectomy or two separate unilateral mastectomies
- Patients must be at least 52 years of age as of the beginning of the Report Period and must be less than 65 years of age as of the end of the Report Period
- To be counted as having the screening, the patient must have had a Mammogram documented in the past 2 years

Bilateral Mastectomy

Any of the following ever:

- CPT 19300.50 through 19307.50 *or* 19300 through 19307 with modifier 09950 (50 and 09950 modifiers indicate bilateral), or old codes 19180, 19200, 19220, or 19240, with modifier of 50 or 09950
- Procedure ICD-9: 85.42, 85.44, 85.46, 85.48; ICD-10: 0HBV0ZZ, 0HCV0ZZ, 0HTV0ZZ
- POV ICD-10: Z90.13

Two Separate Unilateral Mastectomies

Requires either of the following:

- Must have one code that indicates a right mastectomy and one code that indicates a left mastectomy
- Must have 2 separate occurrences on 2 different dates of service for one code that indicates a mastectomy on unknown side and one code that indicates either a right or left mastectomy, or two codes that indicate a mastectomy on unknown side

Right Mastectomy

- POV ICD-10: Z90.11
- Procedure ICD-10: 07T50ZZ, 07T80ZZ, 0HBT0ZZ, 0HCT0ZZ, 0HTT0ZZ

Left Mastectomy

- POV ICD-10: Z90.12
- Procedure ICD-10: 07T60ZZ, 07T90ZZ, 0HBU0ZZ, 0HCU0ZZ, 0HTU0ZZ

Mastectomy on Unknown Side

- CPT 19300 through 19307, or old codes 19180, 19200, 19220, 19240
- Procedure ICD-9: 85.41, 85.43, 85.45, 85.47

Screening Mammogram

- Radiology or CPT 77052 through 77059, 76090 (old code), 76091 (old code), 76092 (old code), G0206, G0204, G0202
- POV ICD-9: V76.11 screening mammogram for high risk patient, V76.12 other screening mammogram, 793.80 Abnormal mammogram, unspecified, 793.81 Mammographic microcalcification, 793.89 Other abnormal findings on radiological exam of breast; ICD-10: R92.0, R92.1, R92.8, Z12.31
- Procedure ICD-9: 87.36 Xerography of breast, 87.37 Other Mammography; ICD-10: BH00ZZZ, BH01ZZZ, BH02ZZZ
- Women's Health procedure called Mammogram Screening, Mammogram Diagnosis Bilateral, Mammogram Diagnosis Unilateral and where the mammogram result does *not* have "ERROR/DISREGARD"

Colorectal Cancer Screening

To be eligible for this screening:

- Patients must be Active Clinical ages 50 through 75 years and not have a documented history ever of colorectal cancer or total colectomy
- To be counted as having the screening, patients must have had any of the following:
 - FOBT or FIT during the Report Period
 - Flexible Sigmoidoscopy in the past 5 years
 - Colonoscopy in the past 10 years

Colorectal Cancer

- POV ICD-9: 153.*, 154.0, 154.1, 197.5, V10.05; ICD-10: C18.*, C19, C20, C78.5, Z85.030, Z85.038
- CPT G0213 through G0215 (old codes), G0231 (old code)

Total Colectomy

- Procedure ICD-9: 45.8*; ICD-10: 0DTE*ZZ
- CPT 44150 through 44151, 44152 (old code), 44153 (old code), 44155 through 44158, 44210 through 44212

FOBT or FIT

- CPT 82270, 82274, 89205 (old code), G0328, G0394 (old code)
- LOINC taxonomy
- Site-populated taxonomy BGP GPRA FOB TESTS

Flexible Sigmoidoscopy

- Procedure ICD-9: 45.24; ICD-10: 0DJD8ZZ
- CPT 45330 through 45345, G0104

Colonoscopy

- Procedure ICD-9: 45.22, 45.23, 45.25, 45.42, 45.43; ICD-10: 0D5E4ZZ, 0D5E8ZZ, 0D5F4ZZ, 0D5F8ZZ, 0D5G4ZZ, 0D5G8ZZ, 0D5H4ZZ, 0D5H8ZZ, 0D5K4ZZ, 0D5K8ZZ, 0D5L4ZZ, 0D5L8ZZ, 0D5M4ZZ, 0D5M8ZZ, 0D5N4ZZ, 0D5N8ZZ, 0D9E3ZX, 0D9E4ZX, 0D9E7ZX, 0D9E8ZX, 0D9F3ZX, 0D9F4ZX, 0D9F7ZX, 0D9F8ZX, 0D9G3ZX, 0D9G4ZX, 0D9G7ZX, 0D9G8ZX, 0D9H3ZX, 0D9H4ZX, 0D9H7ZX, 0D9H8ZX, 0D9K3ZX, 0D9K4ZX, 0D9K7ZX, 0D9K8ZX, 0D9L3ZX, 0D9L4ZX, 0D9L7ZX, 0D9L8ZX, 0D9M3ZX, 0D9M4ZX, 0D9M7ZX, 0D9M8ZX, 0D9N3ZX, 0D9N4ZX, 0D9N7ZX, 0D9N8ZX, 0DBE3ZX, 0DBE4ZX, 0DBE7ZX, 0DBE8ZX, 0DBE8ZZ, 0DBF3ZX, 0DBF4ZX, 0DBF7ZX, 0DBF8ZX, 0DBF8ZZ, 0DBG3ZX, 0DBG4ZX, 0DBG7ZX, 0DBG8ZX, 0DBG8ZZ, 0DBH3ZX, 0DBH4ZX, 0DBH7ZX, 0DBH8ZX, 0DBH8ZZ, 0DBK3ZX, 0DBK4ZX, 0DBK7ZX, 0DBK8ZX, 0DBK8ZZ, 0DBL3ZX, 0DBL4ZX, 0DBL7ZX, 0DBL8ZX, 0DBL8ZZ, 0DBM3ZX, 0DBM4ZX, 0DBM7ZX, 0DBM8ZX, 0DBM8ZZ, 0DBN3ZX, 0DBN4ZX, 0DBN7ZX, 0DBN8ZX, 0DBN8ZZ, 0DJD8ZZ
- CPT 44388 through 44394, 44397, 45355, 45378 through 45387, 45391, 45392, G0105, G0121, G9252, G9253

2.5.4.6 Patient List

List of patients 24 through 75 years of age with comprehensive cancer screening, if any.

2.5.5 Tobacco Use and Exposure Assessment

2.5.5.1 Owner and Contact

Chris Lamer, PharmD, Epidemiology Program: Dayle Knutson

2.5.5.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; *not* reported to OMB and Congress)

2.5.5.3 Denominators

1. Active Clinical patients ages 5 and older. Broken down by gender and age groups: 5 through 13 years, 14 through 17 years, 18 through 24 years, 25 through 44 years, 45 through 64 years, 65 years and older (HP 2020).
2. Pregnant female User Population patients with no documented miscarriage or abortion.

2.5.5.4 Numerators

1. Patients screened for tobacco use during the Report Period (during the past 20 months for pregnant female patients denominator).
2. Patients identified during the Report Period (during the past 20 months for pregnant female patients denominator) as current tobacco users.
 - A. Current smokers
 - B. Current smokeless tobacco users
3. Patients exposed to ETS during the Report Period (during the past 20 months for pregnant female patients denominator).

2.5.5.5 Definitions

Pregnancy

Any of the following:

- The Currently Pregnant field in Reproductive Factors file set to "Yes" during the Report Period.
- At least two visits during the past 20 months, where the primary provider is not a CHR (Provider code 53) with any of the following:
 - POV ICD-9: 640.*3, 641.*3, 642.*3, 643.*3, 644.*3, 645.*3, 646.*3, 647.*3, 648.*3, 649.*3, 651.*3, 652.*3, 653.*3, 654.*3, 655.*3, 656.*3,

657.*3, 658.*3, 659.*3, 660.*3, 661.*3, 662.*3, 663.*3, 665.*3, 668.*3, 669.*3, 671.*3, 673.*3, 678.*3, 679.*3, V22.0 through V23.9, V24.*, V27.*, V28.81, V28.82, V28.89, V72.42, V89.01 through V89.09; ICD-10: O09.00 through O10.02, O10.111 through O10.12, O10.211 through O10.22, O10.311 through O10.32, O10.411 through O10.42, O10.911 through O10.92, O11.1 through O15.1, O15.9 through O24.02, O24.111 through O24.12, O24.311 through O24.32, O24.41*, O24.811 through O24.82, O24.911 through O24.92, O25.10 through O25.2, O26.00 through O26.62, O26.711 through O26.72, O26.811 through O26.93, O29.011 through O30.93, O31.* through O48.*, O60.0*, O61.* through O66.*, O68, O69.*, O71.00 through O71.1, O71.89, O71.9, O74.0 through O75.81, O75.89, O75.9, O76 through O77.*, O88.011 through O88.02, O88.111 through O88.12, O88.211 through O88.22, O88.311 through O88.32, O88.811 through O88.82, O90.3, O91.011 through O91.019, O91.111 through O91.119, O91.211 through O91.219, O92.011 through O92.019, O92.20, O92.29, O98.011 through O98.02, O98.111 through O98.12, O98.211 through O98.22, O98.311 through O98.32, O98.411 through O98.42, O98.511 through O98.52, O98.611 through O98.62, O98.711 through O98.72, O98.811 through O98.82, O98.911 through O98.92, O99.011 through O99.02, O99.111 through O99.12, O99.210 through O99.214, O99.280 through O99.284, O99.310 through O99.314, O99.320 through O99.324, O99.330 through O99.334, O99.340 through O99.344, O99.350 through O99.354, O99.411 through O99.42, O99.511 through O99.52, O99.611 through O99.62, O99.711 through O99.72, O99.810, O99.814, O99.820, O99.824, O99.830, O99.834, O99.840 through O99.844, O99.89, O9A.111 through O9A.12, O9A.211 through O9A.22, O9A.311 through O9A.32, O9A.411 through O9A.42, O9A.511 through O9A.52, Z03.7*, Z32.01, Z33.1, Z34.*, Z36.

- Procedure ICD-9: 72.*, 73.*, 74.*
- CPT 59000-59076, 59300, 59320, 59400-59426, 59510, 59514, 59610, 59612, 59618, 59620, 76801-76828

Pharmacy-only visits (Clinic code 39) will not count toward these two visits. If the patient has more than two pregnancy-related visits during the past 20 months, CRS will use the first two visits in the 20-month period. In addition, the patient must have at least one pregnancy-related visit occurring during the reporting period.

The patient must not have a documented miscarriage or abortion occurring after the second pregnancy-related visit or the date the Currently Pregnant field was set to "Yes". The time period is extended to include patients who were pregnant during the Report Period but who had their tobacco assessment prior to that.

Miscarriage

- Occurring after the second pregnancy POV and during the past 20 months
 - POV ICD-9: 630, 631, 632, 633*, 634*; ICD-10: O03.9
 - CPT 59812, 59820, 59821, 59830

Abortion

- Occurring after the second pregnancy POV and during the past 20 months
 - POV ICD-9: 635*, 636*, 637*; ICD-10: O00.* through O03.89, O04.*, Z33.2
 - CPT 59100, 59120, 59130, 59136, 59150, 59151, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260 through S2267
 - Procedure ICD-9: 69.01, 69.51, 74.91, 96.49; ICD-10: 0WHR73Z, 0WHR7YZ, 10A0***, 3E1K78Z, 3E1K88Z

Tobacco Screening

Time frame for pregnant female patients is the past 20 months

- Any Health Factor for category Tobacco, TOBACCO (SMOKING), TOBACCO (SMOKELESS-CHEWING/DIP), TOBACCO (EXPOSURE)
- Tobacco-related diagnoses (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 305.1, 305.1* (old codes), 649.00 through 649.04, V15.82 (tobacco-related diagnosis); ICD-10: F17.2*, O99.33*, Z72.0, Z87.891
- Dental code 1320
- Patient Education codes containing “TO-”, “-TO”, “-SHS”, 305.1, 305.1* (old codes), 649.00 through 649.04, V15.82, D1320, 99406, 99407, G0375 (old code), G0376 (old code), 1034F, 1035F, 1036F, 1000F, G8455 through G8457 (old codes), G8402 (old code), G8453 (old code), G9275, G9276, or SNOMED codes 160603005, 160604004, 160605003, 160606002, 160619003, 191887008, 191888003, 191889006, 228494002, 228504007, 228514003, 228515002, 228516001, 228517005, 228518000, 230059006, 230060001, 230062009, 230063004, 230064005, 230065006, 266920004, 428041000124106, 428061000124105, 428071000124103, 449868002, 59978006, 65568007, 77176002, 81703003, 82302008, 89765005.
- CPT D1320, 99406, 99407, G0375 (old code), G0376 (old code), G8455 through G8457 (old codes), G8402 (old code), G8453 (old code), G9275, G9276, 1034F (Current Tobacco Smoker), 1035F (Current Smokeless Tobacco User), 1036F (Current Tobacco Non-User), 1036F (Current Tobacco Non-User), 1000F (Tobacco Use Assessed)

Tobacco Users

Time frame for pregnant female patients is the past 20 months

- Health Factors: Current Smoker, Current Smokeless, Current Smoker and Smokeless, Cessation-Smoker, Cessation-Smokeless, Current Smoker, status unknown, Current smoker, every day, Current smoker, some day, Heavy Tobacco Smoker, Light Tobacco Smoker
- POV ICD-9: 305.1, 305.10 through 305.12 (old codes), 649.00 through 649.04; ICD-10: F17.2*0, F17.2*3, F17.2*8, F17.2*9, O99.33*, Z72.0
- CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F, 1035F, G8455 (old code), G8456 (old code), G8402 (old code), G8453 (old code), G9276

Current Smokers

Time frame for pregnant female patients is the past 20 months

- Health Factors: Current Smoker, Current Smoker and Smokeless, Cessation-Smoker, Current Smoker, status unknown, Current smoker, every day, Current smoker, some day, Heavy Tobacco Smoker, Light Tobacco Smoker
- POV ICD-9: 305.1, 305.10 through 305.12 (old codes), 649.00 through 649.04; ICD-10: F17.200, F17.203 through F17.210, F17.213 through F17.290, F17.293 through F17.299, O99.33*
- CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F, G8455 (old code), G8402 (old code), G8453 (old code)

Current Smokeless

Time frame for pregnant female patients is the past 20 months

- Health Factors: Current Smokeless, Current Smoker and Smokeless, or Cessation-Smokeless
- POV ICD-10: F17.220, F17.223 through F17.229
- CPT 1035F, G8456 (old code)

ETS

Time frame for pregnant female patients is the past 20 months

- Health Factors: Smoker in Home, Exposure to ETS

2.5.5.6 Patient List

List of patients 5 and older with documented tobacco screening, if any.

2.5.6 Tobacco Cessation

2.5.6.1 Owner: Contact

Chris Lamer, PharmD, Epidemiology Program: Dayle Knutson

2.5.6.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.5.6.3 Denominators

1. GPRA: Active clinical patients identified as current tobacco users or tobacco users in cessation. Broken down by gender and age groups: younger than 12 years, 12 through 17 years, 18 years and older.
2. User Population patients identified as current tobacco users or tobacco users in cessation. Broken down by gender and age groups: younger than 12 years, 12 through 17 years, 18 years and older.

2.5.6.4 Numerators

1. Patients who have received tobacco cessation counseling or received a prescription for a smoking cessation aid anytime during the Report Period.
2. Patients identified as having quit their tobacco use anytime during the Report Period.
3. GPRA: Patients who received tobacco cessation counseling, received a prescription for a tobacco cessation aid, or quit their tobacco use anytime during the Report Period.

2.5.6.5 Definitions

Denominator

Current Tobacco Users or Tobacco Users in Cessation:

CRS will search first for all health factors documented in the Tobacco, TOBACCO (SMOKING) and TOBACCO (SMOKELESS – CHEWING/DIP) categories during the Report Period.

If health factor(s) are found and at least one of them is one of the health factors listed below, the patient is counted as a current tobacco user or tobacco user in cessation. The patient is not counted as receiving cessation counseling.

Tobacco User Health Factors (TUHF):

- Cessation-Smoker
- Cessation-Smokeless
- Current Smoker
- Current Smokeless
- Current Smoker and Smokeless
- Current Smoker, status unknown
- Current Smoker, every day
- Current Smoker, some day
- Heavy Tobacco Smoker
- Light Tobacco Smoker

If a health factor is found and it is *not* a TUHF, CRS will then search for CPT 1034F or 1035F documented after the health factor. If one of these codes is found, the patient will be considered a tobacco user.

If no health factor was found, CRS will then search for any of the following codes documented during the Report Period:

- Tobacco-related diagnoses (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 305.1, 305.10 through 305.12 (old codes), 649.00 through 649.04; ICD-10: F17.2*0, F17.2*3, F17.2*8, F17.2*9, O99.33*, Z72.0
- CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F, 1035F, G8455 (old code), G8456 (old code), G8402 (old code), G8453 (old code), G9276

If any of these codes are found, the patient will be considered a tobacco user.

If no health factor or other tobacco user-defining code listed above was found during the specified timeframe, CRS will then search for the most recent health factor in both the TOBACCO (SMOKING) and TOBACCO (SMOKELESS – CHEWING/DIP) categories documented during an *expanded* timeframe of any time prior to the Report Period. For example, a patient with the most recent health factor being documented 5 years prior to the Report Period.

Note: If multiple health factors were documented on the same date and if any of them are TUHF(s), all of the health factors will be considered as TUHF(s).

If a health factor is found during the expanded timeframe, and is a TUHF, the patient will be considered a potential tobacco user.

If a health factor is found during the expanded timeframe and it is not one of the TUHFs, CRS will then search for CPT 1034F or 1035F documented after the health factor. If one of these codes is found, the patient will be considered a potential tobacco user.

If no health factor was found, CRS will then search for any of the following codes documented through the beginning of the Report Period:

- Tobacco-related diagnoses (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 305.1, 305.10 through 305.12 (old codes), 649.00 through 649.04; ICD-10: F17.2*0, F17.2*3, F17.2*8, F17.2*9, O99.33*, Z72.0
- CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F, 1035F, G8455 (old code), G8456 (old code), G8402 (old code), G8453 (old code), G9276

If any of these codes are found, the patient will be considered a potential tobacco user. If one of these codes is not found, the patient is considered a non-tobacco user and will not be included in the denominator.

If the patient is considered a potential tobacco user, CRS will then search for diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 305.13 Tobacco use in remission (old code), V15.82; ICD-10: F17.2*1, Z87.891 with a date occurring after the health factor date and through the beginning of the Report Period. If one of these diagnoses is found, the patient will be considered as having quit their tobacco use and will not be included in the denominator. If a diagnosis is not found, the patient is included as a current tobacco user and will be included in the denominator.

Tobacco Cessation Counseling

Any of the following documented anytime during the Report Period:

- Patient education codes containing "TO-", "-TO", "-SHS", 305.1, 305.1* (old codes), 649.00 through 649.04, D1320, 99406, 99407, G0375 (old code), G0376 (old code), 4000F, G8402, G8453, or SNOMED codes 160603005, 160604004, 160605003, 160606002, 160619003, 191887008, 191888003, 191889006, 228494002, 228504007, 228514003, 228515002, 228516001, 228517005, 228518000, 230059006, 230060001, 230062009, 230063004, 230064005, 230065006, 266920004, 428041000124106, 428061000124105, 428071000124103, 449868002, 59978006, 65568007, 77176002, 81703003, 82302008, 89765005.

- Clinic code 94 (tobacco cessation clinic)
- Dental code 1320
- CPT D1320, 99406, 99407, G0375 (old code), G0376 (old code), 4000F, G8402, G8453

Prescription for Tobacco Cessation Aid

Any of the following documented anytime during the Report Period:

- Prescription for medication in the site-populated BGP CMS SMOKING CESSATION MEDS taxonomy that does not have a comment of RETURNED TO STOCK
- Prescription for any medication with name containing “NICOTINE PATCH”, “NICOTINE POLACRILEX”, “NICOTINE INHALER”, “NICOTINE NASAL SPRAY” that does not have a comment of RETURNED TO STOCK
- CPT 4001F

Quit Tobacco Use

Any of the following documented anytime during the Report Period *and* after the date of the code found indicating the patient was a current tobacco user:

- Diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 305.13 Tobacco use in remission (old code), V15.82; ICD-10: F17.2*1, Z87.891
- Health Factor (looks at the last documented health factor): Previous Smoker, Previous Smokeless, Previous (former) smoker, Previous (former) smokeless

2.5.6.6 GPRA 2016 Description

During GPRA Year 2016, achieve the target rate of 49.1% for the proportion of tobacco-using patients who receive tobacco cessation intervention or quit tobacco use.

2.5.6.7 Patient List

List of tobacco users with tobacco cessation intervention, if any, or who have quit tobacco use.

2.6 Behavioral Health Group

2.6.1 Alcohol Screening (FAS Prevention)

2.6.1.1 Owner and Contact

Beverly Cotton, IHS Division of Behavioral Health (DBH), Carolyn Aoyama, CNM, MPH

2.6.1.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.6.1.3 Denominators

1. GPRA: Female Active Clinical patients ages 14 to 46 (child-bearing age).
2. Female User Population patients ages 14 to 46.

2.6.1.4 Numerators

1. GPRA: Patients screened for alcohol use, had an alcohol-related diagnosis or procedure, received alcohol-related patient education, during the Report Period.

Note: This numerator does *not* include refusals.

- A. Patients with alcohol screening during the Report Period.
 - B. Patients with alcohol-related diagnosis or procedure during the Report Period.
 - C. Patients with alcohol-related patient education during the Report Period.
2. Patients who were screened positive for alcohol use.

2.6.1.5 Definitions

Alcohol Screening

Any of the following during the Report Period:

- Exam code 35
- Any CAGE Alcohol Health Factor
- POV ICD-9: V11.3, V79.1, or Behavioral Health System (BHS) Problem code 29.1

- CPT 99408, 99409, G0396, G0397, H0049, H0050, 3016F
- Measurement in PCC or Behavioral Health (BH) of AUDT, AUDC, or CRFT

Alcohol-Related Diagnosis or Procedure

Any of the following during the Report Period:

- Alcohol-related Diagnosis
 - POV, Current PCC or BHS Problem List ICD-9: 303.*, 305.0*, 291.*, 357.5*; ICD-10: F10.1*, F10.20, F10.220 through F10.29, F10.920 through F10.982, F10.99, G62.1
 - BHS POV or Problem Codes 10, 12.1, 14.2, 17.1, 18.1, 20.1, 22.1, 27, 29
- Alcohol-related Procedure
 - Procedure ICD-9: 94.46, 94.53, 94.61 through 94.63, 94.67 through 94.69

Alcohol-Related Patient Education

Any of the following during the Report Period:

- All Patient Education codes containing “AOD-” or “-AOD”, “CD-” or “-CD” (old codes), or V11.3, V79.1, 303.*, 305.0*, 291.*, 357.5*, 99408, 99409, G0396, G0397, H0049, H0050, 3016F, or SNOMED codes 15167005, 18653004, 191471000, 191475009, 191476005, 191477001, 191478006, 191480000, 191802004, 191804003, 191805002, 191811004, 191812006, 191813001, 19303008, 281004, 284591009, 288281000119100, 29212009, 30491001, 34938008, 41083005, 42344001, 53936005, 61144001, 66590003, 7052005, 7200002, 73097000, 78524005, 79578000, 8635005.

Positive Screen for Alcohol Use

Any of the following for patients with alcohol screening:

- Exam code 35 Alcohol Screening result of “Positive”
- Health factor of CAGE result of 1/4, 2/4, 3/4 or 4/4
- CPT G0396, G0397, 99408, 99409
- AUDT result of greater than or equal (\geq) to 8, AUDC result of greater than or equal to (\geq) 4 for men and greater than or equal to (\geq) 3 for women, CRFT result of 2 to 6

2.6.1.6 GPRA 2016 Description

During GPRA Year 2016, establish a baseline for the proportion of female patients ages 14 through 46 years who receive screening for alcohol use.

2.6.1.7 Patient List

List of female patients with documented alcohol screening and result if any.

2.6.2 Screening, Brief Intervention, and Referral to Treatment (SBIRT)**2.6.2.1 Owner: Contact**

Beverly Cotton, IHS Division of Behavioral Health (DBH)

2.6.2.2 National Reporting

NATIONAL (included in IHS Performance Report; *not* reported to OMB and Congress)

2.6.2.3 Denominators

1. Active Clinical Plus BH patients age 9 through 75 years. Broken down by gender and age groups: 9 through 12, 13 through 18, 19 through 24, 25 through 34, 45 through 54, 65 through 75.
2. Active Clinical Plus BH patients age 9 through 75 years screened positive for risky or harmful alcohol use during the Report Period. Broken down by gender and age groups: 9 through 12, 13 through 18, 19 through 24, 25 through 34, 45 through 54, 65 through 75.

2.6.2.4 Numerators

1. Patients screened in Ambulatory Care for risky or harmful alcohol use.
 - A. Patients screened positive for risky or harmful alcohol use.
 - B. Patients provided a brief negotiated interview (BNI) or Brief Intervention (BI) in Ambulatory care within 7 days of screen.
2. Patients provided a brief negotiated interview (BNI) or Brief Intervention (BI) in Ambulatory Care within 7 days of screen.
 - A. Patients who received a BNI/BI on same day as screen.
 - B. Patients who received a BNI/BI 1-3 days after screen.
 - C. Patients who received a BNI/BI 4-7 days after screen.
 - D. Patients who were referred treatment within 7 days of screen.

2.6.2.5 Definitions

Ambulatory Care

- Service Category A (Ambulatory)

Screening for Risky or Harmful Alcohol Use

Any of the following:

- Exam code 35
- Any Alcohol Health Factor (i.e., CAGE)
- POV ICD-9: V79.1 Screening for Alcoholism
- CPT G0396, G0397, H0049, H0050, 99408 (old code), 99409 (old code), 3016F
- Measurement in PCC of AUDT, AUDC, CRFT

Positive Screen for Risky or Harmful Alcohol Use

Any of the following for the screening performed:

- Exam code 35 Alcohol Screening result of Positive
- Health factor of CAGE result of 1/4, 2/4, 3/4 or 4/4
- Any of the following:
 - AUDT result ≥ 8
 - AUDC result ≥ 4 (men)
 - AUDC result ≥ 3 (women)
 - CRFT result ≥ 2 and CRFT result ≤ 6

BNI/BI

Any of the following documented at the Ambulatory Care visit or within seven days of the Ambulatory Care visit at a face-to-face visit, which excludes chart reviews and telecommunication visits:

- CPT G0396, G0397, H0050, 99408 (old code), 99409 (old code), 96150 through 96155
- Patient education code containing AOD-BNI, G0396, G0397, H0050, 99408, 99409, 96150 through 96155

Referral to Treatment

- Patient education code AOD-TX

2.6.2.6 Patient List

- List of patients with screening for risky or harmful alcohol use, results of screen, BNI/BI, and referral, if any.

2.6.3 Intimate Partner (Domestic) Violence Screening

2.6.3.1 Owner and Contact

Beverly Cotton, IHS Division of Behavioral Health (DBH)

2.6.3.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.6.3.3 Denominators

1. GPRA: Female Active Clinical patients ages 14 through 46 years.
2. Female User Population patients ages 14 through 46 years.

2.6.3.4 Numerators

1. GPRA: Patients screened for or diagnosed with IPV/DV during the Report Period.

Note: This numerator does *not* include refusals.

- A. Patients with documented IPV/DV exam.
- B. Patients with IPV/DV related diagnosis.
- C. Patients provided with IPV/DV patient education or counseling.

2.6.3.5 Definitions

IPV/DV Screening

Defined as at least one of the following:

- **IPV/DV Screening**
 - Exam code 34
 - BHS IPV/DV exam
- **IPV/DV Related Diagnosis**
 - POV, Current PCC or BHS Problem List ICD-9: 995.80 through 83, 995.85, V15.41, V15.42, V15.49; ICD-10: T74.11XA, T74.21XA,

T74.31XA, T74.91XA, T76.11XA, T76.21XA, T76.31XA, T76.91XA,
Z91.410

– BHS POV 43.*, 44.*

- **IPV/DV Patient Education**

– Patient Education codes containing “DV-” or “-DV”, 995.80 through 995.83, 995.85, V15.41, V15.42, V15.49, or SNOMED 3027571011, 3027627017, 371772001, 406138006, 412732008, 429746005, 431027007, 432527004

- **IPV/DV Counseling**

– POV ICD-9: V61.11; ICD-10: Z69.11

2.6.3.6 GPRA 2016 Description

During GPRA Year 2016, establish a baseline for the proportion of female patients ages 14 through 46 years who receive screening for domestic violence.

2.6.3.7 Patient List

List of female patients 13 years of age and older with documented IPV/DV screening, if any.

2.6.4 Depression Screening

2.6.4.1 Owner and Contact

Beverly Cotton, IHS Division of Behavioral Health (DBH)

2.6.4.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.6.4.3 Denominators

1. GPRAMA: Active Clinical patients ages 18 and older. Broken down by gender.
 - A. Active Clinical patients ages 65 and older. Broken down by gender
2. Active Diabetes patients, defined as Active Clinical patients diagnosed with diabetes prior to the Report Period, *and* at least two visits during the Report Period, *and* two DM-related visits ever. Broken down by gender.

3. Active coronary heart disease (CHD) patients, defined as Active Clinical patients diagnosed with CHD prior to the Report Period, *and* at least two visits during the Report Period, *and* two CHD-related visits ever. Broken down by gender.
4. User Population patients ages 18 and older. Broken down by gender.

2.6.4.4 Numerators

1. GPRAMA: Patients screened for depression or diagnosed with mood disorder at any time during the Report Period.

Note: This numerator does *not* include refusals.

- A. Patients screened for depression during the Report Period.
 - B. Patients with a diagnosis of a mood disorder during the Report Period.
 - C. Patients who were screened in a Behavioral Health clinic.
2. Patients with depression-related education in past year.

Note: Depression-related patient education does not count toward the GPRAMA numerator and is included as a separate numerator only.

2.6.4.5 Definitions

Diabetes

First DM Purpose of Visit ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.* recorded in the V POV file prior to the Report Period.

CHD

- POV ICD-9: 410.0 through 413.*, 414.0 through 414.9, 429.2; ICD-10: I20.0 through I22.8, I24.0 through I25.83, I25.89, I25.9, Z95.5
- One or more Coronary Artery Bypass Graft (CABG) or Percutaneous Coronary Interventions (PCI) procedures, defined as any of the following:
 - CABG Procedure
 - POV ICD-9: V45.81; ICD-10: Z95.1
 - CPT 33510 through 33514, 33516 through 33519, 33521 through 33523, 33530, 33533 through 33536, 33572, 35500, 35600, S2205 through S2209
 - Procedure ICD-9: 36.1*, 36.2*; ICD-10: 02100**, 021049*, 02104A*, 02104J*, 02104K*, 02104Z*, 02110**, 021149*, 02114A*, 02114J*,

02114K*, 02114Z*, 02120**, 021249*, 02124A*, 02124J*, 02124K*, 02124Z*, 02130**, 021349*, 02134A*, 02134J*, 02134K*, 02134Z*

– PCI Procedure

- POV ICD-9: V45.82; ICD-10: Z95.5, Z98.61
- CPT 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980 (old code), 92982 (old code), 92995 (old code), G0290, C9600, C9602, C9604, C9606, C9607
- Procedure ICD-9: 00.66, 36.01 (old code), 36.02 (old code), 36.05, (old code), 36.06 through 36.07; ICD-10: 02703**, 02704**, 02713**, 02714**, 02723**, 02724**, 02733**, 02734**

Depression Screening

Any of the following:

- Exam code 36
- POV ICD-9: V79.0
- CPT 1220F, 3725F, G0444
- BHS Problem code 14.1 (screening for depression)
- Measurement in PCC or BH of PHQ2 or PHQ9

Mood Disorders

At least two visits in PCC or BHS during the Report Period with POV for: Major Depressive Disorder, Dysthymic Disorder, Depressive Disorder NOS, Bipolar I or II Disorder, Cyclothymic Disorder, Bipolar Disorder NOS, Mood Disorder Due to a General Medical Condition, Substance-induced Mood Disorder, or Mood Disorder NOS. These POV codes are:

- ICD-9: 296.*, 291.89, 292.84, 293.83, 300.4, 301.13, 311; ICD-10: F06.31 through F06.34, F1*.*4, F10.159, F10.180, F10.181, F10.188, F10.259, F10.280, F10.281, F10.288, F10.959, F10.980, F10.981, F10.988, F30.*, F31.0 through F31.71, F31.73, F31.75, F31.77, F31.81 through F31.9, F32.* through F39
- BHS POV 14, 15

Depression-Related Patient Education

Any of the following during the Report Period:

- Patient education codes containing “DEP-” (depression), 296.2* or 296.3*, “BH-” (behavioral and social health), 290 through 319, 995.5*, or 995.80 through 995.85, “SB-” (suicidal behavior) or 300.9, or “PDEP-” (postpartum depression) or 648.44, or SNOMED codes 14183003, 15193003, 15639000, 18818009, 191610000, 191611001, 191613003, 191616006, 191659001,

192080009, 19527009, 19694002, 20250007, 231504006, 231542000,
2506003, 25922000, 2618002, 268621008, 28475009, 3109008, 319768000,
320751009, 33078009, 35489007, 36170009, 36474008, 36923009,
370143000, 38451003, 38694004, 39809009, 40379007, 40568001,
42925002, 430852001, 442057004, 48589009, 63778009, 66344007,
67711008, 69392006, 71336009, 73867007, 75084000, 75837004, 76441001,
77486005, 77911002, 78667006, 79298009, 81319007, 83176005, 832007,
84760002, 85080004, 87512008

Behavioral Health Clinic

Clinic codes C4, C9, 14, 43, 48

2.6.4.6 GPRA 2016 Description

During GPRA Year 2016, achieve the target rate of 67.2% for the proportion of adults ages 18 and older who receive annual screening for depression.

2.6.4.7 Patient List

List of patients with documented depression screening or diagnosed with mood disorder, if any.

2.6.5 Antidepressant Medication Management

2.6.5.1 Owner and Contact

IHS Division of Behavioral Health (DBH)

2.6.5.2 National Reporting

Not reported nationally

2.6.5.3 Denominators

1. As of the 120th day of the Report Period, Active Clinical Plus BH patients 18 years and older who were diagnosed with a new episode of depression and treated with antidepressant medication in the past year.
2. As of the 120th day of the Report Period, User Population patients 18 years and older who were diagnosed with a new episode of depression and treated with antidepressant medication in the past year.

2.6.5.4 Numerators

1. Effective Acute Phase Treatment: Patients who filled a sufficient number of separate prescriptions or refills of antidepressant medication for continuous treatment of at least 84 days (12 weeks).
2. Effective Continuation Phase Treatment: Patients who filled a sufficient number of separate prescriptions or refills of antidepressant medication treatment to provide continuous treatment for at least 180 days (6 months).

2.6.5.5 Definitions

Major Depression

POV ICD-9: 296.20 through 296.25, 296.30 through 296.35, 298.0, 311; ICD-10: F32.0 through F32.4, F32.8 through F33.3, F33.41, F33.9

Index Prescription (Rx) Start Date

The date of the earliest prescription for antidepressant medication filled during this period.

Antidepressant Medications

Medication taxonomy BGP HEDIS ANTIDEPRESSANT MEDS.

- Medications are: Tricyclic antidepressants (TCA) and other cyclic antidepressants, Selective serotonin reuptake inhibitors (SSRI), Monoamine oxidase inhibitors (MAOI), Serotonin-norepinephrine reuptake inhibitors (SNRI), and other antidepressants. Medications must not have a comment of RETURNED TO STOCK.

Denominator Inclusions

To be included in the denominator, patient must meet the following condition:

- Filled a prescription for an antidepressant medication (see the list of medications above) within the 121st day of the year prior to the Report Period to the 120th day of the Report Period. For example, if Report Period is July 1, 2015 through June 30, 2016, patient must have filled a prescription during November 01, 2014 through October 29, 2015. In V Medication, Date Discontinued must not be equal to the prescription, (i.e., visit date).

Denominator Exclusions

Patients with any of the following will be excluded from the denominator:

- Patients who did not have a diagnosis of major depression in an inpatient, outpatient, ED, intensive outpatient or partial hospitalization setting during the 60 days prior to the IPSD (inclusive) through 60 days after the IPSD (inclusive).

- Patients who had a new or refill prescription for antidepressant medication (see the list of medications that follows) within 105 days prior to the Index Rx Start Date are excluded as they do not represent new treatment episodes.

Effective Acute Phase Treatment Numerator

For all antidepressant medication prescriptions filled (see the list of medications that follows) within 114 days of the Index Rx Date, from V Medication CRS counts the days prescribed (i.e., treatment days) from the Index Rx Date until a total of 84 treatment days has been established. If the patient had a total gap exceeding 30 days or if the patient does not have 84 treatment days within the 114 day timeframe, the patient is not included in the numerator.

Note: If a medication was started and then discontinued, CRS will recalculate the number of Days Prescribed by subtracting the prescription date (i.e., visit date) from the V Medication Discontinued Date. For example:

- Rx Date: November 15, 2016
- Discontinued Date: November 19, 2016

Recalculated number of Days Prescribed:
 $November\ 19,\ 2016 - November\ 15,\ 2016 = 4$

Example of Patient Included in Numerator:

- First prescription:
 - Index Rx Date: November 1, 2015
 - Number of Days Prescribed: 30
 $November\ 1,\ 2015 + 30\ days = December\ 1,\ 2015$

Prescription covers the patient through December 1, 2015
- Second prescription:
 - Rx Date: December 15, 2015
 - Number of Days Prescribed: 30:
 - Gap #1 equals 14 days:
 $December\ 15,\ 2015 - December\ 1,\ 2015 = 14\ days$

Prescription covers the patient through January 14, 2016.
- Third prescription:
 - Rx Date: January 10, 2016
 - Number of Days Prescribed: 30
 - No gap days

November 1, 2015 + 114 days = February 23, 2016

Prescription covers the patient through February 13, 2016.

- Patient's 84th treatment day occurs on February 7, 2016:

February 7, 2016 ≤ February 23, 2016

Number of gap days = 14, which is < 30

Patient is included in the Numerator.

Example of Patient Not Included in Numerator:

- First prescription:

- Index Rx Date: November 1, 2015

- Number of Days Prescribed: 30

November 1, 2015 + 30 days = December 1, 2015

Prescription covers the patient through December 1, 2015.

- Second prescription:

- Rx Date: December 15, 2015

- Number of Days Prescribed: 30:

- Gap #1 equals 14 days:

December 15, 2015 – December 1, 2015 = 14 days

Prescription covers the patient through January 14, 2016.

- Third prescription:

- Rx Date: February 1, 2016

- Number of Days Prescribed: 30

- Gap #2 equals 18 days:

February 1, 2016 – January 14, 2016 = 18

- Total number of gap days = 32:

14 + 18 = 32

Patient is not included in the numerator.

Effective Continuation Phase Treatment Numerator

For all antidepressant medication prescriptions (see the previous list of medications) filled within 231 days of the Index Rx Date, CRS counts the days prescribed (i.e., treatment days) (from V Medication) from the Index Rx Date until a total of 180 treatment days has been established. If the patient had a total

gap exceeding 51 days or if the patient does not have 180 treatment days within the 231 day timeframe, the patient is not included in the numerator.

Note: If a medication was started and then discontinued, CRS will recalculate the number of Days Prescribed by subtracting the prescription date (i.e., visit date) from the V Medication Discontinued Date. For example:
 - Rx Date: November 15, 2016
 - Discontinued Date: November 19, 2016
 Recalculated number of Days Prescribed:
November 19, 2016 – November 15, 2016 = 4

2.6.5.6 Patient List

List of patients with new depression diagnosis and acute phase treatment (APT) and continuation phase treatment (CONPT), if any.

2.7 Cardiovascular Disease Related Group

2.7.1 Obesity Assessment

2.7.1.1 Owner and Contact

Nutrition Program, Alberta Becenti

2.7.1.2 Denominators

1. Active Clinical patients ages 2 through 74 years. Broken down by gender and age groups: 2 through 5 years, 6 through 11 years, 12 through 19 years, 20 through 24 years, 25 through 34 years, 35 through 44 years, 45 through 54 years, 55 through 74 years.
2. User Population patients ages 2 through 74 years. Broken down by gender and age groups: 2 through 5 years, 6 through 11 years, 12 through 19 years, 20 through 24 years, 25 through 34 years, 35 through 44 years, 45 through 54 years, 55 through 74 years.

2.7.1.3 Numerators

1. Patients for whom BMI can be calculated.

Note: This numerator does *not* include refusals.

- A. For those with a BMI calculated, patients considered overweight but not obese using BMI and standard tables.
 - B. For those with a BMI calculated, patients considered obese using BMI and standard tables.
 - C. Total of overweight and obese.
2. Patients with documented refusal in past year.

2.7.1.4 Definitions

BMI

CRS calculates BMI at the time the report is run, using NHANES II. For 18 and under, a height and weight must be taken on the same day any time during the Report Period. For ages 19 through 50 years, height and weight must be recorded within last 5 years, not required to be on the same day. For over 50 years of age, height and weight within last 2 years, not required to be recorded on same day. Overweight but not obese is defined as BMI of 25 through 29 for adults ages 19 years and older. Obese is defined as BMI of 30 or more for adults 19 years of age and older. For ages 2 through 18 years, definitions are based on standard tables.

Patients whose BMI either is greater or less than the Data Check Limit range shown in the BMI Standard Reference Data Table in PCC will not be included in the report counts for Overweight or Obese.

Refusals

Include REF (refused), NMI, and UAS (unable to screen) and must be documented during the past year. For ages 18 years and under, both the height and weight must be refused on the same visit at any time during the past year. For ages 19 years and older, the height and weight must be refused during the past year and are not required to be on the same visit.

2.7.1.5 Patient List

List of patients with current BMI, if any.

2.7.2 Childhood Weight Control

2.7.2.1 Owner and Contact

Dr. Ann Bullock

2.7.2.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.7.2.3 Denominators

1. GPRA: Active Clinical Patients 2 to 5 years for whom a BMI could be calculated. Broken down by gender and age groups: 2, 3, 4, 5.
2. User Population Patients 2 to 5 years for whom a BMI could be calculated.

2.7.2.4 Numerators

1. Patients with BMI in the 85th to 94th percentile
2. GPRA: Patients with a BMI at or above the 95th percentile.
3. Patients with a BMI at or above the 85th percentile.

2.7.2.5 Definitions

Age

All patients for whom a BMI could be calculated and who are between the ages of 2 and 5 at the beginning of the Report Period and who do not turn age 6 during the Report Period are included in this measure. Age in the age groups is calculated based on the date of the most current BMI found. For example, a patient may be 2 at the beginning of the time period but is 3 at the time of the most current BMI found. That patient will fall into the Age 3 group.

BMI

CRS looks for the most recent BMI in the Report Period. CRS calculates BMI at the time the report is run, using NHANES II. A height and weight must be taken on the same day any time during the Report Period. The BMI values for this measure reported differently than in Obesity Assessment since this age group is children ages 2 to 5, whose BMI values are age-dependent. The BMI values are categorized as Overweight for patients with a BMI in the 85th to 94th percentile and Obese for patients with a BMI at or above the 95th percentile.

A patient whose BMI either is greater or less than the Data Check Limit range shown in Table 2-2 will not be included in the report counts for Overweight or Obese.

Table 2-1: Data Check Limit

Low-High Ages	Sex	BMI (Overweight)	BMI (Obese)	Data Check Limits BMI >	Data Check Limits BMI <
2-2	Male	17.7	18.7	36.8	7.2
2-2	Female	17.5	18.6	37.0	7.1
3-3	Male	17.1	18.0	35.6	7.1
3-3	Female	17.0	18.1	35.4	6.8
4-4	Male	16.8	17.8	36.2	7.0
4-4	Female	16.7	18.1	36.0	6.9
5-5	Male	16.9	18.1	36.0	6.9
5-5	Female	16.9	18.5	39.2	6.8

2.7.2.6 GPRA 2016 Description

During GPRA Year 2016, achieve the long-term target rate of 22.8% for the proportion of children with a BMI of 95% or higher.

2.7.2.7 Patient List

List of patients ages 2 through 5 years, with current BMI.

2.7.3 Weight Assessment and Counseling for Nutrition and Physical Activity

2.7.3.1 Owner and Contact

Alberta Becenti and Samantha Interpreter, RD

2.7.3.2 Denominators

1. Active Clinical patients ages 3 and older. Broken down by gender and age groups: 3 through 11, 12 through 17, 18 and older.

2.7.3.3 Numerators

1. Patients with comprehensive assessment, defined as having BMI documented, counseling for nutrition, and counseling for physical activity during the Report Period.
2. Patients with BMI documented during the Report Period.

3. Patients with counseling for nutrition during the Report Period.
4. Patients with counseling for physical activity during the Report Period.

2.7.3.4 Definitions

Age

Age is calculated at the end of the Report Period.

BMI

Any of the following during the Report Period:

- CRS calculates BMI at the time the report is run, using NHANES II. For 18 and under, a height and weight must be taken on the same day any time during the Report Period. For ages 19 through 50 years, height and weight must be recorded within last 5 years, not required to be on the same day. For over 50 years of age, height and weight within last 2 years, not required to be recorded on same day.
- POV ICD-9: V85*; ICD-10: Z68.20 through Z68.54

Counseling for nutrition

- CPT 97802 through 97804, G0270, G0271, G0447, S9449, S9452, S9470
- POV ICD-9: V65.3; ICD-10: Z71.3
- Patient Education codes ending “-N” or “-MNT” (or old code “-DT” (Diet)) or containing V65.3, 97802 through 97804, G0270, G0271, G0447, S9449, S9452, S9470

Counseling for physical activity

- CPT G0447, S9451
- POV ICD-9: V65.41
- Patient education codes ending “-EX” (Exercise) or containing V65.41, G0447, or S9451

2.7.3.5 Patient List

List of patients ages 3 and older with assessments, if any.

2.7.4 Nutrition and Exercise Education for At Risk Patients

2.7.4.1 Owner and Contact

Patient Education Program: Chris Lamer, PharmD
Nutrition Program: Alberta Becenti

2.7.4.2 National Reporting

Not reported nationally

2.7.4.3 Denominators

1. Active Clinical patients ages 6 and older considered overweight (including obese). Broken down by gender.
 - A. Active Clinical patients ages 6 and older considered obese. Broken down by age and gender and age groups.
2. Active Diabetic patients, defined as Active Clinical patients diagnosed with diabetes prior to the Report Period, *and* at least two visits during the Report Period, *and* two DM-related visits ever.

2.7.4.4 Numerators

1. Patients provided with medical nutrition therapy during the Report Period.
2. Patients provided with nutrition education during the Report Period.
3. Patients provided with exercise education during the Report Period.
4. Patients provided with other related exercise and nutrition (lifestyle) education.

2.7.4.5 Definitions

Diabetes

First DM POV ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.* recorded in the V POV file prior to the Report Period.

Overweight Categories

Defined as including both obese and overweight categories calculated by BMI.

- **Overweight**
 - Ages 19 years and older, BMI greater than or equal to 25.
- **Obese**

- Ages 19 years and older, BMI greater than or equal to 30.
- For ages 18 years and under, definition based on standard tables. CRS calculates BMI at the time the report is run, using NHANES II. For ages 18 years and under, a height and weight must be taken on the same day any time during the Report Period. For ages 19 through 50 years, height and weight must be recorded within last 5 years, not required to be on the same day. For over ages 50 years, height and weight within last 2 years, not required to be recorded on same day.

Medical Nutrition Therapy

- CPT 97802 through 97804, G0270, G0271
- Primary or secondary provider codes 07, 29
- Clinic codes 67, 36

Nutrition Education

- Patient Education codes ending “-N” or “-MNT” (or old code “-DT” (Diet)) or containing V65.3, 97802 through 97804, G0270, G0271
- POV ICD-9: V65.3; ICD-10: Z71.3

Exercise Education

POV ICD-9: V65.41 exercise counseling or patient education codes ending “-EX” (Exercise) or containing V65.41.

Related Exercise and Nutrition Education

- Patient education codes ending “-LA” (lifestyle adaptation) or containing “OBS-” (obesity) or 278.00, 278.01, S9449, S9451, S9452, S9470, or SNOMED codes 111036000, 162863004, 162863004, 162864005, 162864005, 170798000, 190965006, 190966007, 238131007, 238132000, 238133005, 238134004, 238136002, 248311001, 248312008, 270486005, 275947003, 276792008, 290439001, 292464007, 293481008, 294493008, 295509007, 296526005, 297500005, 298464002, 360566006, 363247006, 408512008, 413487000, 414438005, 414916001, 414917005, 414918000, 414919008, 414920002, 415530009, 444862003, 444862003, 44772007, 450451007, 48499001, 5036006, 53146006, 62999006, 703316004, 705131003, 80660001, 82793005
- CPT S9449, S9451, S9452, S9470

2.7.4.6 Patient List

List of at risk patients, with education if any.

2.7.5 Physical Activity Assessment

2.7.5.1 Owner and Contact

Patient Education Program: Chris Lamer, PharmD

Nutrition Program: Alberta Becenti

2.7.5.2 Denominators

1. Active Clinical patients ages 5 and older. Broken down by gender and age groups: 5 through 11, 12 through 19, 20 through 24, 25 through 34, 35 through 44, 45 through 54, 55 through 74, 75 and older.
2. Numerator 1 (Active Clinical Patients assessed for physical activity during the Report Period). Broken down by gender and age groups: 5 through 11, 12 through 19, 20 through 24, 25 through 34, 35 through 44, 45 through 54, 55 through 74, 75 and older.
3. User Population patients ages 5 and older. Broken down by gender.
4. Numerator 1 (User Population Patients assessed for physical activity during the Report Period). Broken down by gender.

2.7.5.3 Numerators

1. Patients assessed for physical activity during the Report Period.
 - A. Patients from Numerator 1 who have received exercise education following their physical activity assessment.
 - B. Patients from Numerator 1 who have set at least one exercise goal following their physical activity assessment.

2.7.5.4 Definitions

Physical Activity Assessment

Any health factor for category Activity Level documented during the Report Period.

Exercise Education

- POV ICD-9: V65.41 exercise counseling
- Patient education codes ending “-EX” (Exercise) or containing V65.41

Exercise Goal

- Patient Goal with Goal Type of "Physical Activity" and Goal Status of "Goal Set".

2.7.5.5 Patient List

List of patients with physical activity assessment and any exercise education or goals.

2.7.6 Comprehensive Health Screening

2.7.6.1 Owner and Contact

CAPT Jeff Salvon-Harman, MD

2.7.6.2 Denominators

1. Active Clinical patients ages 2 years and older.
2. Active Clinical patients ages 2 years and older.
3. Active Clinical patients ages 12 through 75 years.
4. Active Clinical patients ages 18 years and older.
5. Female Active Clinical patients ages 14 through 46 years.
6. Active Clinical patients ages 5 years and older.
7. Active Clinical patients ages 2 years through 74.
8. Active Clinical patients ages 20 years and older.
9. Active Clinical patients ages 5 years and older.

2.7.6.3 Numerators

1. All Comprehensive Health Screening: Patients with Comprehensive Health Screening for which they are eligible, defined as having alcohol, depression, and IPV/DV screening, BMI calculated, and tobacco use, BP, and physical activity assessed.

Note: This does *not* include refusals.

2. Comprehensive Health Screening: Patients with Comprehensive Health Screening minus physical activity assessment for which they are eligible, defined as having alcohol, depression, and IPV/DV screening, BMI calculated, and tobacco use and BP assessed.

Note: This does *not* include physical activity assessment and does *not* include refusals.

3. Alcohol Screening: Patients screened for alcohol use or had an alcohol-related diagnosis or procedure during the Report Period.

Note: This numerator does *not* include refusals or alcohol-related patient education.

4. Depression Screening: Patients screened for depression or diagnosed with a mood disorder at any time during the Report Period.

Note: This numerator does *not* include refusals.

5. IPV/DV Screening: Patients screened for IPV/DV at any time during the Report Period.

Note: This numerator does *not* include refusals.

6. Tobacco Use Assessed: Patients who have been screened for tobacco use during the Report Period.

7. BMI Available: Patients for whom a BMI could be calculated.

Note: This numerator does *not* include refusals.

8. BP Assessed: Patients with BP value documented at least twice in prior 2 years.
9. Physical Activity Assessed: Patients assessed for physical activity during the Report Period.

2.7.6.4 Definitions

Alcohol Screening

Any of the following during the Report Period:

- Exam code 35
- Any CAGE Alcohol Health Factor
- POV ICD-9: V11.3, V79.1, or BHS Problem code 29.1
- CPT 99408, 99409, G0396, G0397, H0049, H0050, 3016F
- Measurement in PCC or BH of AUDT, AUDC, or CRFT

Alcohol-Related Diagnosis or Procedure

Any of the following during the Report Period:

- Alcohol-Related Diagnosis
 - POV, Current PCC or BHS Problem List ICD-9: 303.*, 305.0*, 291.*, 357.5*; ICD-10: F10.1*, F10.20, F10.220 through F10.29, F10.920 through F10.982, F10.99, G62.1
 - BHS POV 10, 27, 29
- Alcohol-Related Procedure
 - Procedure ICD-9: 94.46, 94.53, 94.61 through 94.63, 94.67 through 94.69

Depression Screening

Any of the following:

- Exam code 36
- POV ICD-9: V79.0
- CPT 1220F, 3725F, G0444
- BHS Problem code 14.1 (screening for depression)
- Measurement in PCC or BH of PHQ2 or PHQ9

Mood Disorders

At least two visits in PCC or BHS during the Report Period with POV for: Major Depressive Disorder, Dysthymic Disorder, Depressive Disorder NOS, Bipolar I or II Disorder, Cyclothymic Disorder, Bipolar Disorder NOS, Mood Disorder Due to a General Medical Condition, Substance-induced Mood Disorder, or Mood Disorder NOS. These POV codes are:

- ICD-9: 296.*, 291.89, 292.84, 293.83, 300.4, 301.13, 311; ICD-10: F06.31 through F06.34, F1*.*4, F10.159, F10.180, F10.181, F10.188, F10.259, F10.280, F10.281, F10.288, F10.959, F10.980, F10.981, F10.988, F30.*, F31.0 through F31.71, F31.73, F31.75, F31.77, F31.81 through F31.9, F32.* through F39
- BHS POV 14, 15

IPV/DV Screening

Defined as at least one of the following:

- **IPV/DV Screening**
 - Exam code 34
 - BHS IPV/DV exam
- **IPV/DV Related Diagnosis**

- POV, Current PCC or BHS Problem List ICD-9: 995.80 through 83, 995.85, V15.41, V15.42, V15.49; ICD-10: T74.11XA, T74.21XA, T74.31XA, T74.91XA, T76.11XA, T76.21XA, T76.31XA, T76.91XA, Z91.410
- BHS POV 43.*, 44.*
- **IPV/DV Patient Education**
 - Patient Education codes containing “DV-” or “-DV”, 995.80 through 83, 995.85, V15.41, V15.42, V15.49, or SNOMED 3027571011, 3027627017, 371772001, 406138006, 412732008, 429746005, 431027007, 432527004
- **IPV/DV Counseling**
 - POV ICD-9: V61.11; ICD-10: Z69.11

Tobacco Screening

- Any Health Factor for category Tobacco, TOBACCO (SMOKING), TOBACCO (SMOKELESS-CHEWING/DIP), TOBACCO (EXPOSURE)
- Tobacco-related diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 305.1, 305.1* (old codes), 649.00 through 649.04, V15.82; ICD-10: F17.2*, O99.33*, Z72.0, Z87.891
- Dental code 1320
- Patient Education codes containing “TO-”, “-TO”, “-SHS,” 305.1, 305.1* (old codes), 649.00 through 649.04, V15.82, D1320, 99406, 99407, G0375 (old code), G0376 (old code), 1034F, 1035F, 1036F, 1000F, G8455 through G8457 (old codes), G8402 (old code), G8453 (old code), G9275, G9276, or SNOMED codes 160603005, 160604004, 160605003, 160606002, 160619003, 191887008, 191888003, 191889006, 228494002, 228504007, 228514003, 228515002, 228516001, 228517005, 228518000, 230059006, 230060001, 230062009, 230063004, 230064005, 230065006, 266920004, 428041000124106, 428061000124105, 428071000124103, 449868002, 59978006, 65568007, 77176002, 81703003, 82302008, 89765005.
- CPT D1320, 99406, 99407, G0375 (old code), G0376 (old code), G8455 through G8457 (old codes), G8402 (old code), G8453 (old code), G9275, G9276, 1034F (Current Tobacco Smoker), 1035F (Current Smokeless Tobacco User), 1036F (Current Tobacco Non-User), 1036F (Current Tobacco Non-User), 1000F (Tobacco Use Assessed)

BMI

CRS calculates BMI at the time the report is run, using NHANES II. For 18 and under, a height and weight must be taken on the same day any time during the Report Period. For ages 19 through 50 years, height and weight must be recorded

within last 5 years, not required to be on the same day. For over 50 years of age, height and weight within last 2 years, not required to be recorded on same day.

BP Documented

Exclusions: When calculating all BPs (using vital measurements or CPT codes), the following visits will be excluded:

- Service Category H (Hospitalization), I (In Hospital), S (Day Surgery), or O (Observation)
- Clinic code 23 (Surgical), 30 (ER), 44 (Day Surgery), C1 (Neurosurgery), or D4 (Anesthesiology)

CRS uses mean of last three BPs documented in the past 2 years. If three BPs are not available, uses mean of last two BPs. If a visit contains more than one BP, the lowest BP will be used, defined as having the lowest systolic value. The mean Systolic value is calculated by adding the last three (or two) systolic values and dividing by three (or two). The mean Diastolic value is calculated by adding the diastolic values from the last three (or two) blood pressures and dividing by three (or two). If the systolic and diastolic values do not *both* meet the current category, then the value that is least controlled determines the category.

If CRS is not able to calculate a mean BP, it will search for CPT 0001F, 2000F, 3074F through 3080F, G9273, G9274 or POV ICD-9: V81.1 documented during the Report Period.

Physical Activity Assessment

- Any health factor for category Activity Level documented during the Report Period.

2.7.6.5 Patient List

List of patients with assessments received, if any.

2.7.7 Cardiovascular Disease and Blood Pressure Control

2.7.7.1 Owner and Contact

Dr. Dena Wilson, Chris Lamer, PharmD, and Mark Veazie

2.7.7.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; *not* reported to OMB and Congress)

2.7.7.3 Denominators

1. Active Clinical patients ages 18 and older. Broken down by gender.
2. Active CHD patients, defined as Active Clinical patients diagnosed with CHD prior to the Report Period, *and* at least two visits during the Report Period, and two CHD-related visits ever. Broken down by gender.
3. User Population patients ages 18 and older. Broken down by gender.

2.7.7.4 Numerators

1. Patients with BP value documented during the Report Period.

2.7.7.5 Definitions

CHD

- POV ICD-9: 410.0 through 413.*, 414.0 through 414.9, 429.2; ICD-10: I20.0 through I22.8, I24.0 through I25.83, I25.89, I25.9, Z95.5
- One or more Coronary Artery Bypass Graft (CABG) or Percutaneous Coronary Interventions (PCI) procedures, defined as any of the following:
 - CABG Procedure
 - POV ICD-9: V45.81; ICD-10: Z95.1
 - CPT 33510 through 33514, 33516 through 33519, 33521 through 33523, 33530, 33533 through 33536, 33572, 35500, 35600, S2205 through S2209
 - Procedure ICD-9: 36.1*, 36.2*; ICD-10: 02100**, 021049*, 02104A*, 02104J*, 02104K*, 02104Z*, 02110**, 021149*, 02114A*, 02114J*, 02114K*, 02114Z*, 02120**, 021249*, 02124A*, 02124J*, 02124K*, 02124Z*, 02130**, 021349*, 02134A*, 02134J*, 02134K*, 02134Z*
 - PCI Procedure
 - POV ICD-9: V45.82; ICD-10: Z95.5, Z98.61
 - CPT 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980 (old code), 92982 (old code), 92995 (old code), G0290, C9600, C9602, C9604, C9606, C9607
 - Procedure ICD-9: 00.66, 36.01 (old code), 36.02 (old code), 36.05, (old code), 36.06 through 36.07; ICD-10: 02703**, 02704**, 02713**, 02714**, 02723**, 02724**, 02733**, 02734**

BP Values (all numerators)

Exclusions: When calculating all BPs (using vital measurements or CPT codes), the following visits will be excluded:

- Service Category H (Hospitalization), I (In Hospital), S (Day Surgery), or O (Observation)
- Clinic code 23 (Surgical), 30 (ER), 44 (Day Surgery), C1 (Neurosurgery), or D4 (Anesthesiology)

CRS uses mean of last three BPs documented during the Report Period. If three BPs are not available, uses mean of the last two BPs, or one BP if there is only one documented. If a visit contains more than one BP, the lowest BP will be used, defined as having the lowest systolic value. The mean Systolic value is calculated by adding the last three (or two) systolic values and dividing by three (or two). The mean Diastolic value is calculated by adding the diastolic values from the last three (or two) blood pressures and dividing by three (or two). If the systolic and diastolic values do not *both* meet the current category, then the value that is least controlled determines the category.

For the BP documented numerator only, if CRS is not able to calculate a mean BP, it will search for CPT 0001F, 2000F, 3074F through 3080F, G9273, G9274 or POV ICD-9: V81.1 documented the Report Period.

2.7.7.6 Patient List

List of Patients 18 years of age and older, or who have CHD with BP value, if any.

2.7.8 Controlling High Blood Pressure – Million Hearts**2.7.8.1 Owner and Contact**

Dr. Dena Wilson, Chris Lamer, PharmD, and Mark Veazie

2.7.8.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.7.8.3 Denominators

1. GPRA: Million Hearts (NQF 0018): User Population patients ages 18 through 85 years diagnosed with hypertension and no documented history of ESRD or current diagnosis of pregnancy. Broken down by age groups 18 through 59 and 60 through 85.

2.7.8.4 Numerators

1. GPRA: Million Hearts (NQF 0018): Patients with blood pressure less than (<) 140/90, i.e., the systolic value is less than (<) 140 AND the diastolic value is less than (<) 90.
2. Patients with blood pressure less than (<) 150/90 (i.e., the mean systolic value is less than 150 AND the mean diastolic value is less than 90).

2.7.8.5 Definitions

Age

Age of the patient is calculated at end of the Report Period.

Hypertension

Diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 401.*; ICD-10: I10 ever through the first 6 months of the Report Period, and at least one hypertension POV during the Report Period.

ESRD

Any of the following ever:

- CPT 36145 (old code), 36147, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831 through 36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90918 through 90925 (old codes), 90935, 90937, 90939 (old code), 90940, 90945, 90947, 90951 through 90970, 90989, 90993, 90997, 90999, 99512, 3066F, G0257, G0308 through G0327 (old codes), G0392 (old code), G0393 (old code), G9231, S2065, S9339
- POV ICD-9: 585.6, V42.0, V45.1 (old code), V45.11 V45.12, V56.*; ICD-10: N18.6, Z48.22, Z49.*, Z91.15, Z94.0, Z99.2
- Procedure ICD-9: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93 through 39.95, 54.98, 55.6*

Pregnancy Definition

Any of the following:

- The Currently Pregnant field in Reproductive Factors file set to "Yes" during the Report Period.
- At least two visits during the Report Period where the primary provider is not a CHR (Provider code 53) with any of the following:
 - POV or Problem diagnosis ICD-9: 640.*3, 641.*3, 642.*3, 643.*3, 644.*3, 645.*3, 646.*3, 647.*3, 648.*3, 649.*3, 651.*3, 652.*3, 653.*3, 654.*3, 655.*3, 656.*3, 657.*3, 658.*3, 659.*3, 660.*3, 661.*3, 662.*3, 663.*3, 665.*3, 668.*3, 669.*3, 671.*3, 673.*3, 678.*3, 679.*3, V22.0

through V23.9, V24.*, V27.*, V28.81, V28.82, V28.89, V72.42, V89.01 through V89.09; ICD-10: O09.00 through O10.02, O10.111 through O10.12, O10.211 through O10.22, O10.311 through O10.32, O10.411 through O10.42, O10.911 through O10.92, O11.1 through O15.1, O15.9 through O24.02, O24.111 through O24.12, O24.311 through O24.32, O24.41*, O24.811 through O24.82, O24.911 through O24.92, O25.10 through O25.2, O26.00 through O26.62, O26.711 through O26.72, O26.811 through O26.93, O29.011 through O30.93, O31.* through O48.*, O60.0*, O61.* through O66.*, O68, O69.*, O71.00 through O71.1, O71.89, O71.9, O74.0 through O75.81, O75.89, O75.9, O76 through O77.*, O88.011 through O88.02, O88.111 through O88.12, O88.211 through O88.22, O88.311 through O88.32, O88.811 through O88.82, O90.3, O91.011 through O91.019, O91.111 through O91.119, O91.211 through O91.219, O92.011 through O92.019, O92.20, O92.29, O98.011 through O98.02, O98.111 through O98.12, O98.211 through O98.22, O98.311 through O98.32, O98.411 through O98.42, O98.511 through O98.52, O98.611 through O98.62, O98.711 through O98.72, O98.811 through O98.82, O98.911 through O98.92, O99.011 through O99.02, O99.111 through O99.12, O99.210 through O99.214, O99.280 through O99.284, O99.310 through O99.314, O99.320 through O99.324, O99.330 through O99.334, O99.340 through O99.344, O99.350 through O99.354, O99.411 through O99.42, O99.511 through O99.52, O99.611 through O99.62, O99.711 through O99.72, O99.810, O99.814, O99.820, O99.824, O99.830, O99.834, O99.840 through O99.844, O99.89, O9A.111 through O9A.12, O9A.211 through O9A.22, O9A.311 through O9A.32, O9A.411 through O9A.42, O9A.511 through O9A.52, Z03.7*, Z32.01, Z33.1, Z34.*, Z36.

- Procedure ICD-9: 72.*, 73.*, 74.*
- CPT 59000-59076, 59300, 59320, 59400-59426, 59510, 59514, 59610, 59612, 59618, 59620, 76801-76828

Pharmacy-only visits (clinic code 39) will not count toward these two visits. If the patient has more than two pregnancy-related visits during the Report Period, CRS will use the first two visits in the Report Period.

The patient must not have a documented miscarriage or abortion occurring after the second pregnancy-related visit or the date the Currently Pregnant field was set to "Yes".

- Miscarriage definition:
 - POV ICD-9: 630, 631, 632, 633*, 634*; ICD-10: O03.9
 - CPT 59812, 59820, 59821, 59830
- Abortion definition:

- POV ICD-9: 635*, 636* 637*; ICD-10: O00.* through O03.89, O04.*, Z33.2
- CPT 59100, 59120, 59130, 59136, 59150, 59151, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260 through S2267,
- Procedure ICD-9: 69.01, 69.51, 74.91, 96.49; ICD-10: 0WHR73Z, 0WHR7YZ, 10A0***, 3E1K78Z, 3E1K88Z

BP Values

Exclusions: When calculating all BPs, the following visits will be excluded:

- Service Category H (Hospitalization), I (In Hospital), S (Day Surgery), or O (Observation)
- Clinic code 23 (Surgical), 30 (ER), 44 (Day Surgery), C1 (Neurosurgery), or D4 (Anesthesiology)

CRS uses the last Blood Pressure documented during the Report Period.

2.7.8.6 GPRA 2016 Description

During GPRA Year 2016, achieve the target rate of 60.6% for the proportion of patients with blood pressure less than (<) 140/90.

2.7.8.7 Patient List

List of patients with hypertension and BP value, if any.

2.7.9 Comprehensive CVD-Related Assessment

2.7.9.1 Owner and Contact

Mark Veazie, Dr. Dena Wilson and Chris Lamer, PharmD

2.7.9.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.7.9.3 Denominators

1. GPRAMA: Active CHD patients ages 22 and older, defined as Active Clinical patients diagnosed with CHD prior to the Report Period, *and* at least two visits during the Report Period, *and* two CHD-related visits ever.
 - A. Active CHD patients 22 and older who are not Active Diabetic.
 - B. Active CHD patients 22 and older who are Active Diabetic.

2. User Pop CHD patients ages 22 and older, defined as User Population patients diagnosed with CHD prior to the Report Period, *and* at least two visits during the Report Period, *and* two CHD-related visits ever.

2.7.9.4 Numerators

1. Patients with BP value documented at least twice in prior 2 years.
2. Patients who have been screened for tobacco use during the Report Period.
3. BMI Available: Patients for whom a BMI could be calculated.
4. Patients who have received any lifestyle adaptation counseling, including medical nutrition therapy, or nutrition, exercise or other lifestyle education or patient goals during the Report Period.
5. GPRAMA: Patients with comprehensive CVD assessment, defined as having BP and tobacco use assessed, BMI calculated and lifestyle counseling.

<p>Note: This does <i>not</i> include depression screening.</p>
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6. Patients screened for depression or diagnosed with a mood disorder or suicide ideation at any time during the Report Period.

2.7.9.5 Definitions

Diabetes

Diagnosed with diabetes (first POV in V POV with ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.*) prior to the current Report Period, *and* at least two visits during the current Report Period, *and* two DM-related visits ever. Patients not meeting these criteria are considered non-diabetics.

CHD

- POV ICD-9: 410.0 through 413.*, 414.0 through 414.9, 429.2; ICD-10: I20.0 through I22.8, I24.0 through I25.83, I25.89, I25.9, Z95.5
- One or more Coronary Artery Bypass Graft (CABG) or Percutaneous Coronary Interventions (PCI) procedures, defined as any of the following:
 - CABG Procedure
 - POV ICD-9: V45.81; ICD-10: Z95.1
 - CPT 33510 through 33514, 33516 through 33519, 33521 through 33523, 33530, 33533 through 33536, 33572, 35500, 35600, S2205 through S2209

- Procedure ICD-9: 36.1*, 36.2*; ICD-10: 02100**, 021049*, 02104A*, 02104J*, 02104K*, 02104Z*, 02110**, 021149*, 02114A*, 02114J*, 02114K*, 02114Z*, 02120**, 021249*, 02124A*, 02124J*, 02124K*, 02124Z*, 02130**, 021349*, 02134A*, 02134J*, 02134K*, 02134Z*
- PCI Procedure
 - POV ICD-9: V45.82; ICD-10: Z95.5, Z98.61
 - CPT 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980 (old code), 92982 (old code), 92995 (old code), G0290, C9600, C9602, C9604, C9606, C9607
 - Procedure ICD-9: 00.66, 36.01 (old code), 36.02 (old code), 36.05, (old code), 36.06 through 36.07; ICD-10: 02703**, 02704**, 02713**, 02714**, 02723**, 02724**, 02733**, 02734**

BP

Having a minimum of two BPs documented in past 2 years. If CRS does not find two BPs, it will search for CPT 0001F, 2000F, 3074F through 3080F, G9273, G9274 or POV ICD-9: V81.1 documented during the past 2 years. The following visits will be excluded:

- Service Category H (Hospitalization), I (In Hospital), S (Day Surgery), O (Observation)
- Clinic codes 23 (Surgical), 30 (ER), 44 (Day Surgery), C1 (Neurosurgery), D4 (Anesthesiology)

Tobacco Screening

At least one of the following:

- Any health factor for category Tobacco, TOBACCO (SMOKING), TOBACCO (SMOKELESS-CHEWING/DIP), TOBACCO (EXPOSURE) documented during Report Period
- Tobacco-related diagnoses (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 305.1, 305.1* (old codes), 649.00 through 649.04, V15.82; ICD-10: F17.2*, O99.33*, Z72.0, Z87.891
- Dental code 1320
- Any patient education code containing "TO-", "-TO", "-SHS", 305.1, 305.1* (old codes), 649.00 through 649.04, V15.82, D1320, 99406, 99407, G0375 (old code), G0376 (old code), 1034F, 1035F, 1036F, 1000F, G8455 through G8457 (old codes), G8402 (old code), G8453 (old code), G9275, G9276, or SNOMED codes 160603005, 160604004, 160605003, 160606002, 160619003, 191887008, 191888003, 191889006, 228494002, 228504007, 228514003, 228515002, 228516001, 228517005, 228518000, 230059006,

230060001, 230062009, 230063004, 230064005, 230065006, 266920004, 428041000124106, 428061000124105, 428071000124103, 449868002, 59978006, 65568007, 77176002, 81703003, 82302008, 89765005.

- CPT D1320, 99406, 99407, G0375 (old code), G0376 (old code), 1034F, 1035F, 1036F, 1000F, G8455 through G8457 (old codes), G8402 (old code), G8453 (old code), G9275, G9276

BMI

CRS calculates BMI at the time the report is run, using NHANES II. For ages 19 through 50 years, height and weight must be recorded within last 5 years, not required to be on the same day. For over 50 years of age, height and weight within last 2 years not required to be recorded on same day.

Medical Nutrition Therapy

- Any of the following:
 - CPT 97802 through 97804, G0270, G0271
 - Primary or secondary provider codes 07, 29
 - Clinic codes 67 (dietary), 36 (WIC)

Nutrition education:

- POV ICD-9: V65.3 dietary surveillance and counseling; ICD-10: Z71.3
- Patient education codes ending “-N” (Nutrition) or “-MNT” or containing V65.3 (or old code “-DT” (Diet))
- Patient Goal with Goal Type of “Nutrition” and Goal Status of "Goal Set", "Goal Met", "Maintaining Goal", or "No Change" during the Report Period

Exercise education:

- POV ICD-9: V65.41 exercise counseling
- Patient education codes ending “-EX” (Exercise) or containing V65.41
- Patient Goal with Goal Type of “Physical Activity” and Goal Status of "Goal Set", "Goal Met", "Maintaining Goal", or "No Change" during the Report Period

Related exercise and nutrition education:

- Patient education codes ending “-LA” (lifestyle adaptation) or containing “OBS-” (obesity) or 278.00 or 278.01, or SNOMED codes 111036000, 162863004, 162863004, 162864005, 162864005, 170798000, 190965006, 190966007, 238131007, 238132000, 238133005, 238134004, 238136002, 248311001, 248312008, 270486005, 275947003, 276792008, 290439001, 292464007, 293481008, 294493008, 295509007, 296526005, 297500005, 298464002, 360566006, 363247006, 408512008, 413487000, 414438005,

414916001, 414917005, 414918000, 414919008, 414920002, 415530009,
444862003, 444862003, 44772007, 450451007, 48499001, 5036006,
53146006, 62999006, 703316004, 705131003, 80660001, 82793005.

Depression Screening and Mood Disorder Diagnosis or Suicide Ideation Diagnosis

Any of the following during the Report Period:

- Depression Screening:
 - Exam code 36
 - POV ICD-9: V79.0
 - CPT 1220F, 3725F, G0444
 - BHS Problem code 14.1 (screening for depression)
 - Measurement in PCC or BH of PHQ2 or PHQ9
- Mood Disorder Diagnosis
 - At least two visits in PCC or BHS during the Report Period with POV for: Major Depressive Disorder, Dysthymic Disorder, Depressive Disorder NOS, Bipolar I or II Disorder, Cyclothymic Disorder, Bipolar Disorder NOS, Mood Disorder Due to a General Medical Condition, Substance-induced Mood Disorder, or Mood Disorder NOS. These POV codes are:
 - ICD-9: 296.*, 291.89, 292.84, 293.83, 300.4, 301.13, 311; ICD-10: F06.31 through F06.34, F1*.*4, F10.159, F10.180, F10.181, F10.188, F10.259, F10.280, F10.281, F10.288, F10.959, F10.980, F10.981, F10.988, F30.*, F31.0 through F31.71, F31.73, F31.75, F31.77, F31.81 through F31.9, F32.* through F39
 - BHS POV 14, 15
- Suicide Ideation Diagnosis
 - POV ICD-9: V62.84; ICD-10: R45.851
 - BHS Problem code 39 during the Report Period

2.7.9.6 GPRA 2016 Description

During GPRA Year 2016, achieve the target rate of 53.3% for the proportion of at-risk patients who have a comprehensive assessment.

2.7.9.7 Patient List

List of patients with assessments received, if any.

2.7.10 Appropriate Medication Therapy after a Heart Attack

2.7.10.1 Owner and Contact

Dr. Dena Wilson, Chris Lamer, PharmD, and Mark Veazie

2.7.10.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; *not* reported to OMB and Congress)

2.7.10.3 Denominators

1. Active Clinical patients 35 and older discharged for an Acute Myocardial Infarction (AMI) during the first 51 weeks of the Report Period and were not readmitted for any diagnosis within 7 days of discharge. Broken down by gender.

2.7.10.4 Numerators

1. Patients with active prescription for or who have a contraindication or previous adverse reaction to beta-blockers.

Note: This numerator does *not* include refusals.

- A. Patients with active prescription for beta-blockers.
 - B. Patients with contraindication or previous adverse reaction to beta-blocker therapy.
2. Patients with active prescription for or who have a contraindication or previous adverse reaction to ASA (aspirin) or other anti-platelet agent.

Note: This numerator does *not* include refusals.

- A. Patients with active prescription for ASA (aspirin) or other anti-platelet agent.
 - B. Patients with contraindication or previous adverse reaction to ASA (aspirin) or other anti-platelet agent.
3. Patients with active prescription for or who have a contraindication or previous adverse reaction to ACEIs/ARBs.

Note: This numerator does *not* include refusals.

- A. Patients with active prescription for ACEIs/ARBs
- B. Patients with contraindication or previous adverse reaction to ACEIs/ARBs

4. Patients with active prescription for or who have a contraindication or previous adverse reaction to statins.

Note: This numerator does *not* include refusals.

- A. Patients with active prescription for statins
- B. Patients with contraindication or previous adverse reaction to statins

5. Patients with active prescriptions for all post-AMI medications (i.e., beta-blocker, ASA or anti-platelet, ACEI/ARB, and statin) or who have a contraindication or previous adverse reaction.

Note: This numerator does *not* include refusals.

2.7.10.5 Definitions

AMI

POV ICD-9: 410.0*-410.9*, 412; ICD-10: I21.*, I22.*, I23.*, I25.2 with Service Category H. If patient has more than one episode of AMI during the first 51 weeks of the Report Period, CRS will include only the first discharge.

Denominator Exclusions

Patients meeting any of the following conditions will be excluded from the denominator.

- Patients with Discharge Type of Irregular (AMA), Transferred, or contains "Death."
- Patients readmitted for any diagnosis within 7 days of discharge.
- Patients with a Diagnosis Modifier of C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable), R (Resolved), S (Suspect, Suspicious), or T (Status Post).
- Patients with a Provider Narrative beginning with "Consider," "Doubtful," "Maybe," "Possible," "Perhaps," "Rule Out," "R/O," "Probable," "Resolved," "Suspect," "Suspicious," or "Status Post."

To be included in the numerators,

A patient must meet one of the following two conditions:

- An active prescription (not discontinued as of (discharge date plus 7 days) and does not have a comment of RETURNED TO STOCK) that was prescribed prior to admission, during the inpatient stay, or within 7 days after discharge. "Active" prescription defined as:

$Days\ Prescribed > (Discharge\ Date + 7\ days - Order\ Date)$

- Have a contraindication or previous adverse reaction to the indicated medication.

Contraindication or previous ADR or allergies are only counted if a patient did not have a prescription for the indicated medication. Patients without a prescription who have a contraindication, ADR, or allergy will be counted in sub-numerator B.

Note: If a medication was started and then discontinued, CRS will recalculate the number of Days Prescribed by subtracting the prescription date (i.e., visit date) from the V Medication Discontinued Date. For example:

- Rx Date: November 15, 2016
- Discontinued Date: November 19, 2016

Recalculated number of Days Prescribed:
 $November\ 19,\ 2016 - November\ 15,\ 2016 = 4$

Numerator Logic

In the logic that follows, “ever” is defined as anytime through the end of the Report Period.

Beta-Blocker Numerator Logic

- **Beta-blocker medication codes**

Defined with medication taxonomy BGP PQA BETA BLOCKER MEDS:

- Noncardioselective Beta Blockers: Carvedilol, Labetalol, Nadolol, Penbutolol, Pindolol, Propranolol, Timolol, Sotalol
- Cardioselective Beta Blockers: Acebutolol, Atenolol, Betaxolol, Bisoprolol, Metoprolol, Nebivolol
- Antihypertensive Combinations: Atenolol-chlorthalidone, Bendroflumethiazide-nadolol, Bisoprolol-hydrochlorothiazide, Hydrochlorothiazide-metoprolol, and Hydrochlorothiazide-propranolol.

- **Contraindications to beta-blockers**

Defined as any of the following occurring ever unless otherwise noted:

- **Asthma.** Two diagnoses (POV) of ICD-9: 493*; ICD-10: J45.* on different visit dates
- **Hypotension.** One diagnosis of ICD-9: 458*; ICD-10: I95.*
- **Heart block greater than 1 degree.** One diagnosis of ICD-9: 426.0, 426.12, 426.13, 426.2, 426.3, 426.4, 426.51, 426.52, 426.53, 426.54, 426.7; ICD-10: I44.1, I44.2, I45.2, I45.3, I45.6

- **Sinus bradycardia.** One diagnosis of ICD-9: 427.81; ICD-10: I49.5, R00.1
- **COPD.** Two diagnoses on different visit dates of ICD-9: 491.2*, 496, 506.4; ICD-10: J44.*, J68.4, J68.8, or a combination of any of these codes, such as one visit with 491.20 and one with 496
- NMI refusal for any beta-blocker at least once during hospital stay through 7 days after discharge date
- CPT G8011 (Clinician documented that AMI patient was not an eligible candidate for beta-blocker at arrival) (old code), G9190 (Documentation of medical reason(s) for not prescribing beta-blocker therapy (e.g., allergy, intolerance, other medical reasons)) at least once during hospital stay through 7 days after discharge date
- **Adverse drug reaction or documented beta blocker allergy**
Defined as any of the following occurring ever:
 - POV ICD-9: 995.0 through 995.3 *and* E942.0
 - Beta block* entry in ART (Patient Allergies File)
 - Beta block*, bblock* or b block* contained within Problem List or in Provider Narrative field for any POV ICD-9: 995.0 through 995.3, V14.8; ICD-10: Z88.8

ASA (aspirin) or Other Anti-Platelet Numerator Logic

- **ASA medication codes**
 - Defined with medication taxonomy DM AUDIT ASPIRIN DRUGS
- **Other antiplatelet medication codes**
 - Defined with medication taxonomy site-populated BGP ANTI-PLATELET DRUGS taxonomy, any medication with VA Drug Class BL700.
- **Contraindications to ASA or other antiplatelet**
Defined as any of the following occurring ever unless otherwise noted:
 - Patients with active prescription for Warfarin (Coumadin) at time of arrival or prescribed at discharge, using site-populated BGP CMS WARFARIN MEDS taxonomy
 - Hemorrhage diagnosis (POV ICD-9: 459.0; ICD-10: R58)
 - NMI refusal for any aspirin at least once during hospital stay through 7 days after discharge date
 - CPT G8008 (Clinician documented that AMI patient was not an eligible candidate to receive aspirin at arrival) (old code) at least once during hospital stay through 7 days after discharge date

- **Adverse drug reaction, documented ASA, or other antiplatelet allergy**

Defined as any of the following occurring ever:

- POV ICD-9: 995.0 through 995.3 *and* E935.3; ICD-10: T39.015* or T39.095*
- Aspirin entry in ART (Patient Allergies File)
- ASA or aspirin contained within Problem List or in Provider Narrative field for any POV ICD-9: 995.0 through 995.3, V14.8; ICD-10: Z88.8

ACEI/ARB Numerator Logic

- **Ace Inhibitor (ACEI) medication codes**

Defined with medication taxonomy BGP HEDIS ACEI MEDS:

- **ACEI medications:** Angiotensin Converting Enzyme Inhibitors (Benazepril, Captopril, Enalapril, Fosinopril, Lisinopril, Moexipril, Perindopril, Quinapril, Ramipril, Trandolopril).
- **Antihypertensive Combinations:** (Amlodipine-benazepril, Benazepril-hydrochlorothiazide, Captopril-hydrochlorothiazide, Enalapril-hydrochlorothiazide, Fosinopril-hydrochlorothiazide, Hydrochlorothiazide-lisinopril, Hydrochlorothiazide-moexipril, Hydrochlorothiazide-quinapril, Trandolapril-verapamil).

- **Contraindications to ACEI** defined as any of the following:

- **Pregnancy:** See the definition that follows
- **Breastfeeding:** defined as POV ICD-9: V24.1; ICD-10: Z39.1 or Breastfeeding Patient Education codes BF-BC, BF-BP, BF-CS, BF-EQ, BF-FU, BF-HC, BF-ON, BF-M, BF-MK, BF-N or containing SNOMED 169745008, 200430001, 405029003, 406213009, 413711008, 413712001 during the Report Period
- **Diagnosis ever for moderate or severe aortic stenosis**
 - POV ICD-9: 395.0, 395.2, 396.0, 396.2, 396.8, 424.1, 425.1, 747.22
- **NMI refusal** for any ACEI at least once during hospital stay through 7 days after discharge date.

- **Adverse drug reaction or documented ACEI allergy**

Defined as any of the following occurring ever:

- POV ICD-9: 995.0 through 995.3 *and* E942.6; ICD-10: T46.4X5*
- Ace inhibitor or ACEI entry in ART (Patient Allergies File)
- Ace i* or ACEI contained within Problem List or in Provider Narrative field for any POV ICD-9: 995.0 through 995.3, V14.8; ICD-10: Z88.8

- **ARB medication codes**

Defined with medication taxonomy BGP HEDIS ARB MEDS:

- **ARB medications:** Angiotensin II Inhibitors (Azilsartan, Candesartan, Eprosartan, Irbesartan, Losartan, Olmesartan, Telmisartan, Valsartan.)
- **Antihypertensive Combinations:** Aliskiren-valsartan, Amlodipine-hydrochlorothiazide-olmesartan, Amlodipine-hydrochlorothiazide-valsartan, Amlodipine-olmesartan, Amlodipine-Telmisartan, Amlodipine-valsartan, Azilsartan-chlorthalidone, Candesartan-hydrochlorothiazide, Eprosartan-hydrochlorothiazide, Hydrochlorothiazide-Irbesartan, Hydrochlorothiazide-Losartan, Hydrochlorothiazide-olmesartan, Hydrochlorothiazide-Telmisartan, Hydrochlorothiazide-Valsartan
- **Contraindications to ARB** defined as any of the following:
 - **Pregnancy:** See the definition that follows
 - **Breastfeeding:** Defined as POV V24.1; ICD-10: Z39.1 or breastfeeding patient education codes BF-BC, BF-BP, BF-CS, BF-EQ, BF-FU, BF-HC, BF-ON, BF-M, BF-MK, BF-N or containing SNOMED 169745008, 200430001, 405029003, 406213009, 413711008, 413712001 during the Report Period
 - **Diagnosis ever for moderate or severe aortic stenosis**
 - POV ICD-9: 395.0, 395.2, 396.0, 396.2, 396.8, 424.1, 425.1, 747.22
 - **NMI refusal** for any ARB at least once during hospital stay through 7 days after discharge date.
- **Adverse drug reaction or documented ARB allergy**
Defined as any of the following occurring ever:
 - POV ICD-9: 995.0 through 995.3 *and* E942.6
 - Angiotensin Receptor Blocker or ARB entry in ART (Patient Allergies File)
 - Angiotensin Receptor Blocker or ARB contained within Problem List or in Provider Narrative field for any POV ICD-9: 995.0 through 995.3, V14.8; ICD-10: Z88.

Statins Numerator Logic:

- **Statin medication codes**

Defined with medication taxonomy BGP PQA STATIN MEDS:

- **Statin medications:** Atorvastatin (Lipitor), Fluvastatin (Lescol), Lovastatin (Altacor, Altoprev, Mevacor), Pravastatin (Pravachol), Pitavastatin (Livalo), Simvastatin (Zocor), Rosuvastatin (Crestor).
- **Statin Combination Products:** Niacin-lovastatin, Niacin-simvastatin, Ezetimibe-simvastatin, Amlodipine-Atorvastatin, Sitagliptin-simvastatin, Ezetimibe-atorvastatin.

- **Contraindications to Statins:** defined as any of the following:
 - **Pregnancy:** See the definition that follows
 - **Breastfeeding:** defined as POV ICD-9: V24.1; ICD-10: Z39.1 or breastfeeding patient education codes BF-BC, BF-BP, BF-CS, BF-EQ, BF-FU, BF-HC, BF-ON, BF-M, BF-MK, BF-N or containing SNOMED 169745008, 200430001, 405029003, 406213009, 413711008, 413712001 during the Report Period
 - **Acute Alcoholic Hepatitis:** defined as POV ICD-9: 571.1; ICD-10: K70.10, K70.11 during the Report Period
 - **NMI refusal** for any statin at least once during hospital stay through 7 days after discharge date.
- **Adverse drug reaction or documented statin allergy**

Defined as any of the following:

- ALT or AST greater than three times the Upper Limit of Normal (ULN) (i.e., Reference High) on two or more consecutive visits during the Report Period
- Creatine Kinase (CK) levels greater than 10 times ULN or CK greater than (>) 10,000 IU/L during the Report Period
- Myopathy or Myalgia, defined as any of the following during the Report Period:
 - POV ICD-9: 359.0 through 359.9, 729.1, 710.5, 074.1; ICD-10: G71.14, G71.19, G72.0, G72.2, G72.89, G72.9, M35.8, M60.80 through M60.9, M79.1
- Any of the following occurring ever:
 - POV ICD-9: 995.0 through 995.3 and E942.9
 - Statin or Statins entry in ART (Patient Allergies File)
 - Statin or Statins contained within Problem List or in Provider Narrative field for any POV ICD-9: 995.0 through 995.3, V14.8; ICD-10: Z88.8

Pregnancy Definition

Any of the following:

- The Currently Pregnant field in Reproductive Factors file set to "Yes" during the Report Period.
- At least two visits during the Report Period where the primary provider is not a CHR (Provider code 53) with any of the following:
 - POV or Problem diagnosis ICD-9: 640.*3, 641.*3, 642.*3, 643.*3, 644.*3, 645.*3, 646.*3, 647.*3, 648.*3, 649.*3, 651.*3, 652.*3, 653.*3,

654.*3, 655.*3, 656.*3, 657.*3, 658.*3, 659.*3, 660.*3, 661.*3, 662.*3, 663.*3, 665.*3, 668.*3, 669.*3, 671.*3, 673.*3, 678.*3, 679.*3, V22.0 through V23.9, V24.*, V27.*, V28.81, V28.82, V28.89, V72.42, V89.01 through V89.09; ICD-10: O09.00 through O10.02, O10.111 through O10.12, O10.211 through O10.22, O10.311 through O10.32, O10.411 through O10.42, O10.911 through O10.92, O11.1 through O15.1, O15.9 through O24.02, O24.111 through O24.12, O24.311 through O24.32, O24.41*, O24.811 through O24.82, O24.911 through O24.92, O25.10 through O25.2, O26.00 through O26.62, O26.711 through O26.72, O26.811 through O26.93, O29.011 through O30.93, O31.* through O48.*, O60.0*, O61.* through O66.*, O68, O69.*, O71.00 through O71.1, O71.89, O71.9, O74.0 through O75.81, O75.89, O75.9, O76 through O77.*, O88.011 through O88.02, O88.111 through O88.12, O88.211 through O88.22, O88.311 through O88.32, O88.811 through O88.82, O90.3, O91.011 through O91.019, O91.111 through O91.119, O91.211 through O91.219, O92.011 through O92.019, O92.20, O92.29, O98.011 through O98.02, O98.111 through O98.12, O98.211 through O98.22, O98.311 through O98.32, O98.411 through O98.42, O98.511 through O98.52, O98.611 through O98.62, O98.711 through O98.72, O98.811 through O98.82, O98.911 through O98.92, O99.011 through O99.02, O99.111 through O99.12, O99.210 through O99.214, O99.280 through O99.284, O99.310 through O99.314, O99.320 through O99.324, O99.330 through O99.334, O99.340 through O99.344, O99.350 through O99.354, O99.411 through O99.42, O99.511 through O99.52, O99.611 through O99.62, O99.711 through O99.72, O99.810, O99.814, O99.820, O99.824, O99.830, O99.834, O99.840 through O99.844, O99.89, O9A.111 through O9A.12, O9A.211 through O9A.22, O9A.311 through O9A.32, O9A.411 through O9A.42, O9A.511 through O9A.52, Z03.7*, Z32.01, Z33.1, Z34.*, Z36.

- Procedure ICD-9: 72.*, 73.*, 74.*
- CPT 59000-59076, 59300, 59320, 59400-59426, 59510, 59514, 59610, 59612, 59618, 59620, 76801-76828

Pharmacy-only visits (clinic code 39) will not count toward these two visits. If the patient has more than two pregnancy-related visits during the Report Period, CRS will use the first two visits in the Report Period.

The patient must not have a documented miscarriage or abortion occurring after the second pregnancy-related visit or the date the Currently Pregnant field was set to "Yes".

- **Miscarriage definition:**

- POV ICD-9: 630, 631, 632, 633*, 634*; ICD-10: O03.9

- CPT 59812, 59820, 59821, 59830
- **Abortion definition:**
 - POV ICD-9: 635*, 636* 637*; ICD-10: O00.* through O03.89, O04.*, Z33.2
 - CPT 59100, 59120, 59130, 59136, 59150, 59151, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260 through S2267,
 - Procedure ICD-9: 69.01, 69.51, 74.91, 96.49; ICD-10: 0WHR73Z, 0WHR7YZ, 10A0***, 3E1K78Z, 3E1K88Z

All Medications Numerator Logic

To be included in this numerator, a patient must have a prescription or a contraindication for *all* of the four medication classes (i.e., beta-blocker, ASA or other anti-platelet, ACEI/ARB, AND statin).

Test Definitions

- **ALT**
 - Site-populated taxonomy DM AUDIT ALT TAX
 - LOINC taxonomy
- **AST**
 - Site-populated taxonomy DM AUDIT AST TAX
 - LOINC taxonomy
- **Creatine Kinase**
 - Site-populated taxonomy BGP CREATINE KINASE TAX
 - LOINC taxonomy

2.7.10.6 Patient List

List of patients with AMI, with appropriate medication therapy, if any.

2.7.11 Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation

2.7.11.1 Owner and Contact

Dr. Dena Wilson and Mark Veazie

2.7.11.2 Denominators

1. User Population patients ages 18 and older who have a documented diagnosis of ischemic stroke or transient ischemic attack (TIA) with documented permanent,

persistent, or paroxysmal atrial fibrillation anytime prior to the end of the Report Period.

2.7.11.3 Numerators

1. Patients who received a prescription for anticoagulant during the Report Period.

2.7.11.4 Definitions

Ischemic Stroke or TIA with Atrial Fibrillation:

POV of any of the following: (ICD-9: 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9; ICD-10: G45.0 through G45.2, G45.8, G45.9, G46.0 through G46.2, I63.*) and POV ICD-9: 427.31; ICD-10: I48.0 through I48.2, I48.91 (atrial fibrillation).

Anticoagulant Therapy

Patient must receive a prescription for Warfarin, aspirin, or other anti-platelet during the Report Period to be counted as receiving anticoagulant therapy.

For all prescriptions, medications must not have a comment of RETURNED TO STOCK.

Warfarin Medication

Any medication in site-populated BGP CMS WARFARIN MEDS taxonomy.

Aspirin Medication

Any medication in site-populated DM AUDIT ASPIRIN DRUGS taxonomy.

Other Anti-Platelet or Anticoagulant Medication

Any medication in the site-populated BGP ANTI-PLATELET DRUGS taxonomy, any medication with VA Drug Class BL700.

2.7.11.5 Patient List

List of patients with stroke or TIA and atrial fibrillation with anticoagulant therapy, if any.

2.7.12 Heart Failure and Evaluation of LVS Function

2.7.12.1 Owner and Contact

Dr. Dena Wilson, Chris Lamer, PharmD, and Mark Veazie

2.7.12.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; *not* reported to OMB and Congress)

2.7.12.3 Denominators

1. Active Clinical ages 18 and older discharged with heart failure during the Report Period.

2.7.12.4 Numerators

1. Patients whose left ventricular systolic (LVS) function was evaluated before arrival, during hospitalization, or is planned for after discharge.

2.7.12.5 Definitions

Age

Age of the patient is calculated as of the hospital admission date

Heart Failure

- POV primary diagnosis code of ICD-9: 398.91, 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9, 429.1, 997.1; ICD-10: I11.0, I13.0, I13.2, I50.* *and* with Service Category H (hospitalization).

Note: If a patient has multiple admissions matching these criteria during the Report Period, the earliest admission will be used.

Denominator Exclusions

Defined as any of the following:

- Patients receiving comfort measures only (i.e., patients who received palliative care and usual interventions were not received because a medical decision was made to limit care).
- Patients with a Discharge Type of Transferred or Irregular or containing "Death."
- Patients who had a left ventricular assistive device (LVAD) or heart transplant procedure during hospitalization.

Comfort Measures

- POV ICD-9: V66.7 (Encounter for palliative care); ICD-10: Z51.5 documented during hospital stay

LVAD or Heart Transplant

Any of the following during hospital stay:

- Procedure ICD-9: 33.6, 37.41, 37.51 through 37.54, 37.61 through 37.66, 37.68; ICD-10: 02HA**Z, 02PA*RZ, 02RK0JZ, 02RL0JZ, 02UA4JZ, 02WA0JZ, 02WA0QZ, 02WA0RZ, 02WA3QZ, 02WA3RZ, 02WA4QZ, 02WA4RZ, 02YA0Z*, 5A02*10, 5A02*16, 5A02*1D

Evaluation of LVS Function

Any of the following:

- An ejection fraction ordered or documented anytime 1 year prior to discharge date, defined as any of the following:
 - Measurement “CEF”
 - Procedure ICD-9: 88.53, 88.54; ICD-10: B205*ZZ, B206*ZZ, B215*ZZ, B216*ZZ
 - CPT 78414, 78468, 78472, 78473, 78480, 78481, 78483, 78494, 93303, 93304, 93307, 93308, 93312, 93314 through 93318, 93350, 93543, 93555
- RCIS (Referred Care Information System) order for Cardiovascular Disorders referral that is ordered during the hospital stay but no later than the hospital discharge date. (RCIS referral defined as:
 - ICD Diagnostic Category Cardiovascular Disorders combined with any of the following CPT Categories: Evaluation or Management, Non-surgical Procedures, or Diagnostic Imaging.)
- Any of the following documented anytime one year prior to discharge date:
 - Echocardiogram: Procedure ICD-9: 88.72, 37.28, 00.24; ICD-10: B245YZZ, B245ZZ4, B245ZZZ, B246YZZ, B246ZZ4, B246ZZZ, B24BYZZ, B24BZZ4, B24BZZZ
 - Nuclear Medicine Test: Procedure ICD-9: 92.2*
 - Cardiac Catheterization with a Left Ventriculogram: Procedure ICD-9: 37.22, 37.23, 88.53, 88.54; ICD-10: 4A02*N7, 4A02*N8, B205*ZZ, B206*ZZ, B215*ZZ, B216*ZZ

2.7.12.6 Patient List

List of Active Clinical heart failure patients 18 and older who received evaluation of LVS function, if any.

2.8 STD-Related Group

2.8.1 HIV Screening

2.8.1.1 Owner and Contact

Lisa Neel, MPH and Dr. Marie Russell

2.8.1.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.8.1.3 Denominators

1. Pregnant Active Clinical patients with no documented miscarriage or abortion during the past 20 months and no recorded HIV diagnosis ever.
2. GPRA: User Population patients ages 13 through 64 with no recorded HIV diagnosis prior to the Report Period.

2.8.1.4 Numerators

1. Patients who were screened for HIV during the past 20 months.
2. GPRA Developmental: Patients who were screened for HIV during the Report Period.

Note: This numerator does *not* include refusals.

3. GPRA: Patients who were screened for HIV at any time before the end of the Report Period.

Note: This numerator does *not* include refusals.

4. GPRA Developmental: Number of HIV screens provided to User Population patients during the Report Period, where the patient was not diagnosed with HIV any time prior to the screen.

Note: This numerator does *not* include refusals. No denominator and is a total count only, not a percentage.

2.8.1.5 Definitions

HIV

Any of the following documented any time prior to the end of the Report Period:

- POV or Problem List entry where the status is not Inactive or Deleted ICD-9: 042, 042.0 through 044.9 (old codes), 079.53, V08, 795.71; ICD-10: B20, B97.35, R75, Z21, O98.711 through O98.73

Pregnancy:

Any of the following:

- The Currently Pregnant field in Reproductive Factors file set to "Yes" during the Report Period.
- At least two visits during the past 20 months from the end of the Report Period, where the primary provider is not a CHR (Provider code 53) with any of the following:
 - POV or problem diagnosis ICD-9: 640.*3, 641.*3, 642.*3, 643.*3, 644.*3, 645.*3, 646.*3, 647.*3, 648.*3, 649.*3, 651.*3, 652.*3, 653.*3, 654.*3, 655.*3, 656.*3, 657.*3, 658.*3, 659.*3, 660.*3, 661.*3, 662.*3, 663.*3, 665.*3, 668.*3, 669.*3, 671.*3, 673.*3, 678.*3, 679.*3, V22.0 through V23.9, V24.*, V27.*, V28.81, V28.82, V28.89, V72.42, V89.01 through V89.09; ICD-10: O09.00 through O10.02, O10.111 through O10.12, O10.211 through O10.22, O10.311 through O10.32, O10.411 through O10.42, O10.911 through O10.92, O11.1 through O15.1, O15.9 through O24.02, O24.111 through O24.12, O24.311 through O24.32, O24.41*, O24.811 through O24.82, O24.911 through O24.92, O25.10 through O25.2, O26.00 through O26.62, O26.711 through O26.72, O26.811 through O26.93, O29.011 through O30.93, O31.* through O48.*, O60.0*, O61.* through O66.*, O68, O69.*, O71.00 through O71.1, O71.89, O71.9, O74.0 through O75.81, O75.89, O75.9, O76 through O77.*, O88.011 through O88.02, O88.111 through O88.12, O88.211 through O88.22, O88.311 through O88.32, O88.811 through O88.82, O90.3, O91.011 through O91.019, O91.111 through O91.119, O91.211 through O91.219, O92.011 through O92.019, O92.20, O92.29, O98.011 through O98.02, O98.111 through O98.12, O98.211 through O98.22, O98.311 through O98.32, O98.411 through O98.42, O98.511 through O98.52, O98.611 through O98.62, O98.711 through O98.72, O98.811 through O98.82, O98.911 through O98.92, O99.011 through O99.02, O99.111 through O99.12, O99.210 through O99.214, O99.280 through O99.284, O99.310 through O99.314, O99.320 through O99.324, O99.330 through O99.334, O99.340 through O99.344, O99.350 through O99.354, O99.411 through O99.42, O99.511 through O99.52, O99.611 through O99.62, O99.711 through O99.72, O99.810, O99.814, O99.820, O99.824,

O99.830, O99.834, O99.840 through O99.844, O99.89, O9A.111 through O9A.12, O9A.211 through O9A.22, O9A.311 through O9A.32, O9A.411 through O9A.42, O9A.511 through O9A.52, Z03.7*, Z32.01, Z33.1, Z34.*, Z36.

- Procedure ICD-9: 72.*, 73.*, 74.*
- CPT 59000-59076, 59300, 59320, 59400-59426, 59510, 59514, 59610, 59612, 59618, 59620, 76801-76828

Pharmacy-only visits (Clinic code 39) will not count toward these two visits. If the patient has more than two pregnancy-related visits during the past 20 months, CRS will use the first two visits in the 20-month period. In addition, the patient must have at least one pregnancy-related visit occurring during the reporting period.

The patient must not have a documented miscarriage or abortion occurring after the second pregnancy-related visit or the date the Currently Pregnant field was set to "Yes". The time period is extended to include patients who were pregnant during the Report Period but whose initial diagnosis (and HIV test) were documented prior to Report Period.

- **Miscarriage:** Occurring after the second pregnancy POV and during the past 20 months.
 - POV ICD-9: 630, 631, 632, 633*, 634*; ICD-10: O03.9
 - CPT 59812, 59820, 59821, 59830
- **Abortion:** Occurring after the second pregnancy POV and during the past 20 months.
 - POV ICD-9: 635*, 636*, 637*; ICD-10: O00.* through O03.89, O04.*, Z33.2
 - CPT 59100, 59120, 59130, 59136, 59150, 59151, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260 through S2267
 - Procedure ICD-9: 69.01, 69.51, 74.91, 96.49; ICD-10: 0WHR73Z, 0WHR7YZ, 10A0***, 3E1K78Z, 3E1K88Z

HIV Screening

- CPT 86689, 86701 through 86703, 87390, 87391, 87534 through 87539
- LOINC taxonomy
- Site-populated taxonomy BGP HIV TEST TAX

For the number of HIV screens provided to User Population patients numerator (count only), a maximum of one HIV screen per patient per day will be counted

Note: The time frame for screening for the pregnant patient's denominator is anytime during the past 20 months and for User Population patients 13 through 64 years of age is anytime during the Report Period.

2.8.1.6 GPRA 2016 Description

During GPRA Year 2016, establish a baseline for the proportion of patients who have ever been screened for HIV.

2.8.1.7 Patient List

List of pregnant patients or User Population patients with documented HIV test, if any.

2.8.2 HIV Quality of Care

2.8.2.1 Owner and Contact

Lisa Neel, MPH, Dr. Marie Russell, and Jonathan Iralu

2.8.2.2 National Reporting

Not reported nationally

2.8.2.3 Denominators

1. User Population patients 13 and older with at least two direct care visits, (i.e., not contract or PRC) during the Report Period with HIV diagnosis *and* one HIV visit in last 6 months.

2.8.2.4 Numerators

1. Patients who received CD4 test only (without HIV viral load) during the Report Period.
2. Patients who received HIV viral load only (without CD4), during the Report Period.
3. Patients who received both CD4 and HIV viral load tests during the Report Period.
4. Total Numerators 1, 2, and 3.
5. Patients who received at least one prescription for an Antiretroviral medication.

2.8.2.5 Definitions

HIV

POV ICD-9: 042, 042.0 through 044.9 (old codes), 079.53, V08, 795.71; ICD-10: B20, B97.35, R75, Z21, O98.711 through O98.73

Lab Test CD4

- CPT 86359, 86360, 86361, G9214
- LOINC taxonomy
- Site-populated taxonomy BGP CD4 TAX

HIV Viral Load

- CPT 87536, 87539, G9242, G9243
- LOINC taxonomy
- Site-populated taxonomy BGP HIV VIRAL TAX

Antiretroviral Medication

Defined with medication taxonomy BGP PQA ANTIRETROVIRAL MEDS. Medications must not have a comment of RETURNED TO STOCK.

Antiretroviral medications are:

- Single Agents (Enfuvirtide, Maraviroc, Atazanavir, Darunavir, Fosamprenavir, Indinavir, Nelfinavir, Ritonavir, Saquinavir, Tipranavir, Dolutegravir, Raltegravir, Delavirdine, Efavirenz, Etravirine, Nevirapine, Abacavir, Didanosine, Emtricitabine, Lamivudine, Stavudine, Tenofovir, Zidovudine, Rilpivirine, Elvitegravir).
- Combination Agents (Lopinavir-Ritonavir, Lamivudine-zidovudine, Darunavir-Cobicistat, Atazanavir-Cobicistat, Abacavir-Lamivudine-Zidovudine, Efavirenz-emtricitabine-Tenofovir, Emtricitabine-tenofovir, Abacavir-lamivudine, Emtricitabine-rilpivirine-Tenofovir, Elvitegravir-cobicistat-emtricitabine-tenofovir, Abacavir-dolutegravir-lamivudine).

2.8.2.6 Patient List

List of patients 13 and older diagnosed with HIV, with CD4 test, viral load or antiretroviral Rx, if any.

2.8.3 Hepatitis C Screening

2.8.3.1 Owner and Contact

Brigg Reilley

2.8.3.2 Denominators

1. User Population patients born between 1945 and 1965 with no recorded Hepatitis C diagnosis.
2. User Population with documented positive Ab result or Hep C diagnosis ever. Broken down by age group of patients born between 1945 and 1965.
3. User Population patients with positive Ab result or Hep C diagnosis and with positive Hepatitis C confirmation result ever. Broken down by age group of patients born between 1945 and 1965.

2.8.3.3 Numerators

1. Patients screened for Hepatitis C ever (Ab test).
 - A. Patients with a positive result.
 - B. Patients with a negative result.
2. Patients with documented positive Ab result ever.
3. Patients with documented Hep C diagnosis ever.
4. Patients who were given a Hepatitis C confirmation test.
 - A. Patients with a positive result.
 - B. Patients with a negative result.
5. Patients who ever had a negative confirmation test twelve weeks or greater after a positive confirmation test (cured).
6. A. Patients who had a negative confirmation test twelve weeks or greater after their most recent positive confirmation test (currently cured).

2.8.3.4 Definitions

Hepatitis C Diagnosis

Any of the following documented any time prior to the end of the Report Period:

- POV or Problem List entry where the status is not Inactive or Deleted: ICD-9: 070.41, 070.44, 070.51, 070.54, 070.70 through 070.71, V02.62; ICD-10: B17.10, B17.11, B18.2, B19.20, B19.21, Z22.52

Hepatitis C Screening (Ab Test)

- CPT 86803
- LOINC taxonomy

- Site-populated taxonomy BGP HEP C TEST TAX

Hepatitis C Confirmation Test

Any of the following documented any time prior to the end of the Report Period:

- CPT 86804, 87520, 87521, 87522, G9203, G9207, G9209
- LOINC taxonomy
- Site-populated taxonomy BGP HEP C CONF TEST TAX

If patient has more than one confirmatory test, CRS will first look for a test with a positive result, and if none is found, then will look for a test with a negative result. If there is no test with a result, CRS will use the first test documented.

For patients ever cured numerator, there must be twelve or more weeks between a positive and negative confirmation test result.

Positive Ab or Confirmation Test Result

Positive test result defined as any number greater than zero, a result starting with ">", a result starting with a number, or containing "Pos", "Positive", "React", "Reactive", "Detec", or "Detected".

Negative Ab or Confirmation Test Result

Negative test result defined as result starting with "<", or containing "Neg", "Negative", "Non", "None detected", "None Detec", or "Not detected"..

2.8.3.5 Patient List

List of patients with documented Hepatitis C screening or confirmatory test ever, if any.

2.8.4 Chlamydia Testing

2.8.4.1 Owner and Contact

Epidemiology Program: Andria Apostolou, PhD, MPH

2.8.4.2 National Reporting

Not reported nationally

2.8.4.3 Denominators

1. Female Active Clinical patients ages 16 through 25 years. Broken down into age groups: 16 through 20 years, 21 through 25 years.

2. Female User Population patients ages 16 through 25 years. Broken down into age groups: 16 through 20 years, 21 through 25 years.

2.8.4.4 Numerators

1. Patients tested for Chlamydia trachomatis during the Report Period.

2.8.4.5 Definitions

Chlamydia

- POV ICD-9: V73.88, V73.98
- CPT 86631, 86632, 87110, 87270, 87320, 87490 through 87492, 87810, 3511F, G9228
- Site-populated taxonomy BGP CHLAMYDIA TESTS
- LOINC taxonomy

2.8.4.6 Patient List

List of patients with documented Chlamydia screening, if any.

2.8.5 Sexually Transmitted Infection (STI) Screening

2.8.5.1 Owner and Contact

Andria Apostolou, PhD, MPH

2.8.5.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; *not* reported to OMB and Congress)

2.8.5.3 Denominators

1. HIV/AIDS screenings needed for key STI incidents for Active Clinical patients that occurred during the defined period. Broken down by gender.

2.8.5.4 Numerators

1. Count only (no percentage comparison to denominator). The total count of Active Clinical patients who were diagnosed with one or more key STIs during the period 60 days prior to the Report Period through the first 300 days of the Report Period. Broken down by gender.

2. Count only (no percentage comparison to denominator). The total count of separate key STI incidents for Active Clinical patients during the defined period.
3. For use with denominator #1: Number of needed HIV/AIDS screenings performed from one month prior to the date of first STI diagnosis of each incident through 2 months after.

Note: This numerator does *not* include refusals.

2.8.5.5 Definitions

Key STIs

Chlamydia, gonorrhea, HIV/AIDS, and syphilis. Key STIs defined with the following POVs:

- Chlamydia: ICD-9: 079.88, 079.98, 099.41, 099.50 through 099.59; ICD-10: A56.*, A74.81 through A74.9
- Gonorrhea: ICD-9: 098.0 through 098.89; ICD-10: A54.*, O98.2*
- HIV/AIDS: ICD-9: 042, 042.0 through 044.9, 079.53, 795.71, V08; ICD-10: B20, B97.35, R75, Z21, O98.711 through O98.73
- Syphilis: ICD-9: 090.0 through 093.9, 094.1 through 097.9; ICD-10: A51.* through A53.*

Logic for Identifying Patients Diagnosed with Key STI (Numerator #1)

Any patient with one or more diagnoses of any of the key STIs defined previously during the period 60 days prior to the beginning of the Report Period through the first 300 days of the Report Period.

Logic for Identifying Separate Incidents of Key STIs (Numerator #2)

One patient may have one or multiple occurrences of one or multiple STIs during the year, except for HIV. An occurrence of HIV is only counted if it is the initial HIV diagnosis for the patient ever. Incidents of an STI are identified beginning with the date of the first key STI diagnosis (see the previous definition) occurring between 60 days prior to the beginning of the Report Period through the first 300 days of the Report Period. A second incident of the same STI (other than HIV) is counted if another diagnosis with the same STI occurs 2 months or more after the initial diagnosis. A different STI diagnosis that occurs during the same 60-day time period as the first STI counts as a separate incident.

Table 2-2: Logic for Identifying Separate Incidents of Key STIs

Date	Visit	Total Incidents
August 1, 2015	Patient screened for Chlamydia	0
August 8, 2015	Patient diagnosed with Chlamydia	1
October 15, 2015	Patient diagnosed with Chlamydia	2
October 25, 2015	Follow-up for Chlamydia	2
November 15, 2015	Patient diagnosed with Chlamydia	2
March 1, 2016	Patient diagnosed with Chlamydia	3

Denominator Logic for Needed Screenings (Denominator #1)

One patient may need multiple screening tests based on one or more STI incidents occurring during the time period.

To be included in the needed HIV screening tests denominator, the count will be derived from the number of separate non-HIV STI incidents. HIV screening tests are recommended for the following key STIs: Chlamydia, Gonorrhea, Syphilis.

“Needed” screenings are recommended screenings that are further evaluated for contraindications. The following are reasons that a recommended screening is identified as not needed (i.e., contraindicated).

- Only one screening for HIV is needed during the relevant time period, regardless of the number of different STI incidents identified. For example, if a patient is diagnosed with Chlamydia and Gonorrhea on the same visit, only one screening is needed for HIV/AIDS.
- A patient with HIV/AIDS diagnosis prior to any STI diagnosis that triggers a recommended HIV/AIDS screening does not need the screening ever.

Numerator Logic

To be counted in the numerator, each needed screening in the denominator must have a corresponding lab test or test refusal documented in the period from 1 month prior to the relevant STI diagnosis date through 2 months after the STI incident.

- **HIV/AIDS Screening**

Any of the following during the specified time period:

- CPT 86689, 86701 through 86703, 87390 through 87391, 87534 through 87539
- Site-populated taxonomy BGP HIV TEST TAX

– LOINC taxonomy

2.8.5.6 Patient List

List of patients diagnosed with one or more STIs during the defined time period with related screenings.

2.9 Other Clinical Measures Group

2.9.1 Asthma

2.9.1.1 Owner and Contact

Chris Lamer, PharmD

2.9.1.2 National Reporting

Not reported nationally

2.9.1.3 Denominators

1. Active Clinical patients. Broken down by age groups: younger than 15 years, 15 through 34 years, 35 through 64 years, 65 years and older.
2. Numerator 1 (Patients who have had two asthma-related visits during the Report Period or with persistent asthma). Broken down by age groups: younger than 15 years, 15 through 34 years, 35 through 64 years, 65 years and older.

2.9.1.4 Numerators

1. Patients who have had two asthma-related visits during the Report Period or with persistent asthma.
 - A. Patients from Numerator 1 who have been hospitalized at any hospital for asthma during the Report Period.
 - B. Patients from Numerator 1 who have visited the ER or Urgent Care for asthma during the Report Period.
 - C. Patients from Numerator 1 who have a Severity of 1.
 - D. Patients from Numerator 1 who have a Severity of 2.
 - E. Patients from Numerator 1 who have a Severity of 3.
 - F. Patients from Numerator 1 who have a Severity of 4.
 - G. Patients from Numerator 1 who have no documented Severity.

2.9.1.5 Definitions

Asthma Visits

Asthma visits are defined as diagnosis (POV) ICD-9: 493.*; ICD-10: J45.*.

Persistent Asthma

Any of the following:

- Problem List entry where the status is not Inactive or Deleted for ICD-9: 493.*; ICD-10: J45.* with Severity of 2, 3 or 4 at *any* time before the end of the Report Period or
- Most recent visit-related asthma entry (i.e., V Asthma) with Severity of 2, 3, or 4 documented *any* time before the end of the Report Period.

Severity

Severity is defined as a Severity of 1, 2, 3 or 4 in an active entry in the PCC Problem List for ICD-9: 493.*; ICD-10: J45.* or in V Asthma.

Hospitalizations

Hospitalizations are defined as service category H with primary POV ICD-9: 493.*; ICD-10: J45.*.

ER and Urgent Care

ER and Urgent Care visits are defined as Clinic codes 30 or 80 with primary POV ICD-9: 493.*; ICD-10: J45.*.

2.9.1.6 Patient List

List of patients diagnosed with asthma and any asthma-related hospitalizations, ER, or Urgent Care visits.

2.9.2 Asthma Assessments

2.9.2.1 Owner and Contact

Chris Lamer, PharmD

2.9.2.2 National Reporting

Not reported nationally

2.9.2.3 Denominators

1. Active Clinical patients ages 5 and older with persistent asthma within the year prior to the beginning of the Report Period and during the Report Period, without a documented history of emphysema or chronic obstructive pulmonary disease (COPD). Broken down by age groups: 5 through 14 years, 15 through 34 years, 35 through 64 years, and 65 years and older.

2.9.2.4 Numerators

1. Patients with asthma management plan during the Report Period.
2. Patients with severity documented at any time before the end of the Report Period.
3. Patients with control documented during the Report Period.
4. Patients who were assessed for number of symptom free days during the Report Period.
5. Patients with number of symptom free days score of 0 through 5.
6. Patients with number of symptom free days score of 6 through 12.
7. Patients with number of symptom free days score of 13 through 14.
8. Patients who were assessed for number of school or work days missed during the Report Period.
9. Patients with number of school or work days missed score of 0 through 2.
10. Patients with number of school or work days missed score of 3 through 7.
11. Patients with number of school or work days missed score of 8 through 14.

2.9.2.5 Definitions

Denominator Exclusions

Patients diagnosed with emphysema or COPD at any time on or before the end of the Report Period are excluded from the denominator.

Emphysema

Any visit at any time on or before the end of the Report Period with POV codes: ICD-9: 492.*, 506.4, 518.1, 518.2; ICD-10: J43.*, J68.4, J68.8, J98.2, J98.3.

COPD

Any visit at any time on or before the end of the Report Period with POV codes: ICD-9: 491.20, 491.21, 491.22, 493.2*, 496, 506.4; ICD-10: J44.*, J68.4, J68.8.

Persistent Asthma

Meeting any of the following four criteria that follow within the year prior to the beginning of the Report Period and during the Report Period:

- At least one visit to Clinic code 30 (Emergency Medicine) with primary diagnosis ICD-9: 493.*; ICD-10: J45.* (asthma)
- At least one acute inpatient discharge with primary diagnosis ICD-9: 493.*; ICD-10: J45.* Acute inpatient discharge defined as Service Category of H
- At least four outpatient visits, defined as Service Categories A, S, or O, with primary or secondary diagnosis of ICD-9: 493.*; ICD-10: J45.* and at least two asthma medication dispensing events (see the definition that follows)
- At least four asthma medication dispensing events (see the definition that follows). If the sole medication was leukotriene modifiers, then must also have at least one visit with POV ICD-9: 493.*; ICD-10: J45.* in the same year as the leukotriene modifier (i.e., during the Report Period or within the year prior to the beginning of the Report Period.), or

Meeting any of the following criteria:

- Problem List entry where the status is not Inactive or Deleted for ICD-9: 493.*; ICD-10: J45.* with Severity of 2, 3 or 4 at any time before the end of the Report Period or
- Most recent visit-related asthma entry (i.e., V Asthma) with Severity of 2, 3, or 4 documented any time before the end of the Report Period.

Dispensing Event

One prescription of an amount lasting 30 days or less. For prescriptions longer than 30 days, divide the days' supply by 30 and round down to convert. For example, a 100-day prescription is equal to 3 dispensing events:

$$100 \div 30 = 3.33, \text{ rounded down to } 3$$

Also, two different prescriptions dispensed on the same day are counted as two different dispensing events. Inhalers should also be counted as one dispensing event.

Note: If a medication was started and then discontinued, CRS will recalculate the number of Days Prescribed by subtracting the prescription date (i.e., visit date) from the V Medication Discontinued Date. For example:

- Rx Date: November 15, 2016
- Discontinued Date: November 19, 2016

Recalculated number of Days Prescribed:
November 19, 2016 – November 15, 2016 = 4

- Asthma medication codes for denominator defined with medication taxonomies:
 - BGP HEDIS ASTHMA MEDS
 - BGP HEDIS ASTHMA LEUK MEDS
 - BGP HEDIS ASTHMA INHALED MEDS
 - Medications are: Antiasthmatic Combinations (Dyphylline-Guaifenesin, Guaifenesin-Theophylline), Antibody Inhibitor (Omalizumab), Inhaled Steroid Combinations (Budesonide-Formoterol, Fluticasone-Salmeterol, Formoterol-Mometasone), Inhaled Corticosteroids (Belclomethasone, Budesonide, Ciclesonide CFC Free, Flunisolide, Fluticasone CFC Free, Mometasone), Lekotriene Modifiers (Montelukast, Zafirlukast, Zileuton), Mast Cell Stabilizers (Cromolyn), Methylxanthines (Aminophylline, Dyphylline, Theophylline), Short-Acting, Inhaled Beta2 Agonists (Albuterol, Levalbuterol, Pirbuterol. Medications must not have a comment of RETURNED TO STOCK.

Asthma Management Plan

Defined as Patient Education code ASM-SMP.

Severity

Severity documented defined as meeting any of the following criteria:

- Problem List entry where the status is not Inactive or Deleted for ICD-9: 493.*; ICD-10: J45.* with Severity of 2, 3 or 4 at any time before the end of the Report Period or
- Most recent visit-related asthma entry (i.e., V Asthma) with Severity of 2, 3, or 4 documented any time before the end of the Report Period.

Control

Control documented defined as ICD-9: 493.*; ICD-10: J45.* with Asthma Control recorded in the V POV file.

Symptom Free Days

Number of symptom free days defined as the most recent V Measurement documented during the Report Period.

School or Work Days Missed

Number of school or work days missed defined as the most recent V Measurement documented during the Report Period.

2.9.2.6 Patient List

List of asthmatic patients with assessments, if any.

2.9.3 Medication Therapy for Persons with Asthma**2.9.3.1 Owner and Contact**

Chris Lamer, PharmD

2.9.3.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; not reported to OMB and Congress)

2.9.3.3 Denominators

1. Active Clinical patients ages 5 through 50 with persistent asthma within the year prior to the beginning of the Report Period and during the Report Period, without a documented history of emphysema or COPD.
2. Active Clinical patients ages 5 and older with persistent asthma within the year prior to the beginning of the Report Period and during the Report Period, without a documented history of emphysema or COPD. Broken down into age groups: 5 through 14 years, 15 through 34 years, 35 through 64 years, and 65 years and older.
3. Active Clinical patients ages 5 and older with persistent asthma within the year prior to the beginning of the Report Period and during the Report Period, without a documented history of emphysema or COPD who had two or more prescriptions for a Long-Acting Beta2 Agonist (LABA) medication during the Report Period. Broken down into age groups: 5 through 14 years, 15 through 34 years, 35 through 64 years, and 65 years and older.

2.9.3.4 Numerators

1. Suboptimal Control: Patients who were dispensed more than three canisters of a short-acting Beta2 Agonist inhaler during the same 90-day period during the Report Period.
2. Absence of Controller Therapy: Patients who were dispensed more than three canisters of short acting Beta2 Agonist inhalers over a 90-day period and who did not receive controller therapy during the same 90-day period.
3. Patients who were prescribed two or more controller therapy medications during the Report Period.
4. Patients who were prescribed two or more inhaled corticosteroid medications during the Report Period.
5. Patients who were not prescribed two or more inhaled corticosteroid medications during the Report Period.

2.9.3.5 Definitions

Denominator Exclusions

Patients diagnosed with emphysema or COPD at any time on or before the end of the Report Period are excluded from the denominator.

Emphysema

Any visit at any time on or before the end of the Report Period with POV codes: ICD-9: 492.*, 506.4, 518.1, 518.2; ICD-10: J43.*, J68.4, J68.8, J98.2, J98.3.

COPD

Any visit at any time on or before the end of the Report Period with POV codes: ICD-9: 491.20, 491.21, 491.22, 493.2*, 496, 506.4; ICD-10: J44.*, J68.4, J68.8.

Persistent Asthma

Meeting any of the following four criteria that follow within the year prior to the beginning of the Report Period and during the Report Period:

- At least one visit to Clinic code 30 (Emergency Medicine) with primary diagnosis ICD-9: 493.*; ICD-10: J45.* (asthma)
- At least one acute inpatient discharge with primary diagnosis ICD-9: 493.*; ICD-10: J45.* Acute inpatient discharge defined as Service Category of H
- At least 4 outpatient visits, defined as Service Categories A, S, or O, with primary or secondary diagnosis of ICD-9: 493.*; ICD-10: J45.* and at least two asthma medication dispensing events (see the definition that follows)

- At least four asthma medication dispensing events (see the definition that follows). If the sole medication was leukotriene modifiers, then must also have at least one visit with POV ICD-9: 493.*; ICD-10: J45.* in the same year as the leukotriene modifier (i.e., during the Report Period or within the year prior to the beginning of the Report Period.), or

Meeting any of the following criteria:

- Problem List entry where the status is not Inactive or Deleted for ICD-9: 493.*; ICD-10: J45.* with Severity of 2, 3 or 4 at any time before the end of the Report Period or
- Most recent visit-related asthma entry (i.e., V Asthma) with Severity of 2, 3, or 4 documented any time before the end of the Report Period.

Dispensing Event

One prescription of an amount lasting 30 days or less. For prescriptions longer than 30 days, divide the days' supply by 30 and round down to convert. For example, a 100-day prescription is equal to 3 dispensing events:

$$100 \div 30 = 3.33, \text{rounded down to } 3$$

Also, two different prescriptions dispensed on the same day are counted as two different dispensing events. Inhalers should also be counted as one dispensing event.

Note: If a medication was started and then discontinued, CRS will recalculate the number of Days Prescribed by subtracting the prescription date (i.e., visit date) from the V Medication Discontinued Date. For example:

- Rx Date: November 15, 2016
- Discontinued Date: November 19, 2016

Recalculated number of Days Prescribed:
November 19, 2016 – November 15, 2016 = 4

- Asthma medication codes for denominator defined with medication taxonomies:
 - BGP HEDIS ASTHMA MEDS
 - BGP HEDIS ASTHMA LEUK MEDS
 - BGP HEDIS ASTHMA INHALED MEDS
 - Medications are: Antiasthmatic Combinations (Dyphylline-Guaifenesin, Guaifenesin-Theophylline), Antibody Inhibitor (Omalizumab), Inhaled Steroid Combinations (Budesonide-Formoterol, Fluticasone-Salmeterol, Formoterol-Mometasone), Inhaled Corticosteroids (Belclomethasone, Budesonide, Ciclesonide CFC Free, Flunisolide, Fluticasone CFC Free,

Mometasone), Lekotriene Modifiers (Montelukast, Zafirlukast, Zileuton), Mast Cell Stabilizers (Cromolyn), Methylxanthines (Aminophylline, Dyphylline, Theophylline), Short-Acting, Inhaled Beta2 Agonists (Albuterol, Levalbuterol, Pirbuterol. Medications must not have a comment of RETURNED TO STOCK.

Numerator Inclusion

To be included in the Suboptimal Control and Absence of Controller Therapy numerators, patient must have one or more non-discontinued prescriptions for short acting Beta2 Agonist inhalers totalling at least four canisters in one 90-day period. Short acting Beta2 Agonist inhaler medications defined with medication taxonomy BGP PQA SABA MEDS. (Medications are: Albuterol, Levalbuterol, Pirbuterol). Medications must not have a comment of RETURNED TO STOCK.

Controller Therapy

At least one non-discontinued prescription of controller therapy medications during the same 90-day period.

Controller Therapy Medications

Controller therapy medications defined with medication taxonomy BGP PQA CONTROLLER MEDS. (Medications are: Beclomethasone, Budesonide, Budesonide-Formoterol, Ciclesonide, Flunisolide, Fluticasone, Fluticasone-Salmeterol, Formoterol, Mometasone, Mometasone-Formoterol, Montelukast, Salmeterol, Theophylline, Zafirlukast, Zileuton). Medications must not have a comment of RETURNED TO STOCK.

Inhaled Corticosteroid Medications

Inhaled corticosteroid medications defined with medication taxonomy BGP PQA ASTHMA INHALED STEROIDS. (Medications are: Beclomethasone, Budesonide, Ciclesonide, Fluticasone, Flunisolide, Fluticasone-salmeterol, Mometasone, Budesonide-formoterol, Mometasone-formoterol) Medications must not have a comment of RETURNED TO STOCK.

LABA Medications

LABA medications defined with medication taxonomy BGP ASTHMA LABA MEDS. (Medications are: Aformoterol, Formoterol, Salmeterol.) Medications must not have a comment of RETURNED TO STOCK.

2.9.3.6 Patient List

List of patients with asthma with asthma medications, if any.

2.9.4 Proportion of Days Covered by Medication Therapy

2.9.4.1 Owner and Contact

Chris Lamer, PharmD

2.9.4.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; not reported to OMB and Congress)

2.9.4.3 Denominators

1. Active Clinical patients ages 18 and older who had two or more prescriptions for beta-blockers during the Report Period.
2. Active Clinical patients ages 18 and older who had two or more prescriptions for RAS Antagonists and no documented history of ESRD during the Report Period.
3. Active Clinical patients ages 18 and older who had two or more prescriptions for calcium channel blockers (CCB) during the Report Period.
4. Active Clinical patients ages 18 and older who had two or more prescriptions for biguanides and no documented history of ESRD during the Report Period.
5. Active Clinical patients ages 18 and older who had two or more prescriptions for sulfonylureas and no documented history of ESRD during the Report Period.
6. Active Clinical patients ages 18 and older who had two or more prescriptions for thiazolidinediones and no documented history of ESRD during the Report Period.
7. Active Clinical patients ages 18 and older who had two or more prescriptions for DiPeptidyl Peptidase (DPP)-IV Inhibitors and no documented history of ESRD during the Report Period.
8. Active Clinical patients ages 18 and older who had two or more prescriptions for Diabetes All Class medications and no documented history of ESRD during the Report Period.
9. Active Clinical patients ages 18 and older who had two or more prescriptions for statins during the Report Period.
10. Active Clinical patients ages 18 and older who had two or more prescriptions for non-warfarin oral anticoagulants during the Report Period.
11. Active Clinical patients ages 18 and older who had two or more prescriptions for antiretroviral agents during the Report Period.

2.9.4.4 Numerators

1. Patients with proportion of days covered (PDC) greater than or equal to 80% during the Report Period.
2. Patients with a gap in medication therapy greater than or equal to 30 days.
3. For use with denominator #11: Patients with PDC greater than or equal to 90% during the Report Period.

2.9.4.5 Definitions

Denominator Inclusion

Patients must have at least two prescriptions for that particular type of medication on two unique dates of service at any time during the Report Period. Medications must not have a comment of RETURNED TO STOCK.

For the Non-warfarin anticoagulants measures, the two unique dates of service must be at least 180 days apart and the patient must have received greater than 60 days supply of the medication during the Report Period. Patients who received one or more prescriptions for warfarin, low molecular weight heparin (LMWH), heparin or an SC Factor Xa inhibitor (defined by medication taxonomy BGP PQA WARFARIN) will be excluded from the denominator.

Index Prescription Start Date

The date when the medication was first dispensed within the Report Period. For all measures except Non-warfarin anticoagulants, this date must be greater than 90 days from the end of the Report Period to be counted in the denominator.

Medications

Medications are defined with the following taxonomies:

- BGP PQA BETA BLOCKER MEDS
 - Beta-blocker medications (Acebutolol HCL, Atenolol, Betaxolol HCL, Bisoprolol fumarate, Carvedilol, Labetalol HCL, Metoprolol succinate, Metoprolol tartrate, Nadolol, Nebivolol HCL, Penbutolol sulfate, Pindolol, Propranolol HCL, Timolol maleate); Beta-blocker combination products (Atenolol-chlorthalidone, Bisoprolol-HCTZ, Nadolol-bendroflumethiazide, Metoprolol-HCTZ, Propranolol-HCTZ)
- BGP PQA RASA MEDS
 - Angiotensin Converting Enzyme Inhibitors (Benazepril, Captopril, Enalapril, Fosinopril, Lisinopril, Moexipril, Perindopril, Quinapril, Ramipril, Trandolopril); Antihypertensive Combinations (Amlodipine-benazepril, Benazepril-HCTZ, Captopril-HCTZ, Enalapril-HCTZ,

Fosinopril-HCTZ, Lisinopril-HCTZ, Moexipril-HCTZ, Quinapril-HCTZ, Trandolapril-verapamil); Angiotensin II Inhibitors (Azilsartan, Candesartan, Eprosartan, Irbesartan, Losartan, Olmesartan, Telmisartan, Valsartan); Antihypertensive Combinations (Aliskiren-valsartan, Amlodipine-valsartan, Amlodipine-valsartan-HCTZ, Amlodipine-olmesartan, Azilsartan-Chlorthalidone, Candesartan-HCTZ, Eprosartan-HCTZ, Irbesartan-HCTZ, Losartan-HCTZ, Olmesartan-amlodipine-HCTZ, Olmesartan-HCTZ, Telmisartan-amlodipine, Telmisartan-HCTZ, Valsartan-HCTZ); Direct Renin Inhibitors (Aliskiren); Direct Renin Inhibitor Combination Products (Aliskiren-amlodipine, Aliskiren-amlodipine-HCTZ, Aliskiren-HCTZ, Aliskiren-valsartan)

- BGP PQA CCB MEDS
 - Calcium-Channel Blocker medications (Amlodipine besylate, Diltiazem HCL, Felodipine, Isradipine, Nifedipine HCL, Nifedipine (long acting only), Verapamil HCL, Nisoldipine); CCB Combination Products (Amlodipine besylate-benazepril HCL, Amlodipine-valsartan, Amlodipine-valsartan-HCTZ, Aliskiren-amlodipine, Aliskiren-amlodipine-HCTZ, Telmisartan-amlodipine, Amlodipine-olmesartan, Trandolapril-verapamil HCL, Amlodipine-atorvastatin, Olmesartan-amlodipine-HCTZ)
- BGP PQA BIGUANIDE MEDS
 - Biguanides (Metformin); Combination Products (Glipizide-metformin, Glyburide-metformin, Rosiglitazone-metformin, Pioglitazone-metformin, Repaglinide-metformin, Sitagliptin-metformin IR-SR, Saxagliptin-metformin SR, Linagliptin-metformin, Alogliptin-metformin, Dapagliflozin-Metformin, Canagliflozin-Metformin)
- BGP PQA SULFONYLUREA MEDS
 - Sulfonylureas (Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide); Combination Products (Glipizide-metformin, Glyburide-metformin, Rosiglitazone-glimepiride, Pioglitazone-glimepiride)
- BGP PQA THIAZOLIDINEDIONE MEDS
 - Thiazolidinediones (Pioglitazone, Rosiglitazone); Combination Products (Rosiglitazone-metformin, Pioglitazone-metformin, Rosiglitazone-glimepiride, Pioglitazone-glimepiride, Alogliptin-pioglitazone)
- BGP PQA DPP IV MEDS
 - DPP-IV Inhibitors (Sitagliptin, Linagliptin, Saxagliptin, Alogliptin); Combination Products (Sitagliptin-metformin IR-SR, Saxagliptin-metformin SR, Sitagliptin-simvastatin, Linagliptin-metformin, Alogliptin-metformin, Alogliptin-pioglitazone, Linagliptin-empagliflozin)

- BGP PQA DIABETES ALL CLASS
 - Biguanide medications (see list above); Sulfonylurea medications (see list above); Thiazolidinedione medications (see list above); DPP-IV Inhibitor medications (see list above); Incretin Mimetic Agents (Albiglutide, Exenatide, Liraglutide, Dulaglutide); Meglitinides (Nateglinide, Repaglinide, Repaglinide-metformin); Sodium glucose co-transporter2 (SGLT2) inhibitors (Canagliflozin, Dapagliflozin, Empagliflozin, Dapagliflozin-Metformin, Linagliptin-empagliflozin, Canagliflozin-Metformin)
- BGP PQA STATIN MEDS
 - Statins (Lovastatin, Rosuvastatin, Fluvastatin, Atorvastatin, Pravastatin, Pitavastatin); Combination Products (Niacin-lovastatin, Atorvastatin-amlodipine, Niacin-simvastatin, Sitagliptin-simvastatin, Ezetimibe-simvastatin, Ezetimibe-atorvastatin)
- BGP PQA NON-WARFARIN ANTICOAG
 - (Apixaban, Dabigatran, Rivaroxaban, Edoxaban)
- BGP PQA WARFARIN
 - (Warfarin, Dalteparin, Fondaparinux, Enoxaparin, Heparin, Tinzaparin)
- BGP PQA ANTIRETROVIRAL MEDS
 - Single Agents (Enfuvirtide, Maraviroc, Atazanavir, Darunavir, Fosamprenavir, Indinavir, Nelfinavir, Ritonavir, Saquinavir, Tipranavir, Dolutegravir, Raltegravir, Delavirdine, Efavirenz, Etravirine, Nevirapine, Abacavir, Didanosine, Emtricitabine, Lamivudine, Stavudine, Tenofovir, Zidovudine, Rilpivirine, Elvitegravir); Combination Agents (Lopinavir-Ritonavir, Lamivudine-zidovudine, Darunavir-Cobicistat, Atazanavir-Cobicistat, Abacavir-Lamivudine-Zidovudine, Efavirenz-emtricitabine-Tenofovir, Emtricitabine-tenofovir, Abacavir-lamivudine, Emtricitabine-rilpivirine-Tenofovir, Elvitegravir-cobicistat-emtricitabine-tenofovir, Abacavir-dolutegravir-lamivudine)

ESRD

Any of the following ever:

- CPT 36145 (old code), 36147, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831 through 36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90918 through 90925 (old codes), 90935, 90937, 90939 (old code), 90940, 90945, 90947, 90951 through 90970, 90989, 90993, 90997, 90999, 99512, G0257, G0308 through G0327 (old codes), G0392 (old code), G0393 (old code), G9231, S2065, S9339

- POV ICD-9: 585.6, V42.0, V45.1 (old code), V45.11 V45.12, V56.*; ICD-10: N18.6, Z48.22, Z49.*, Z91.15, Z94.0, Z99.2
- Procedure ICD-9: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93 through 39.95, 54.98, 55.6*

Each PDC Numerator

Proportion of days covered equals the number of days the patient was covered by at least one drug in the class divided by the number of days in the patient's measurement period.

The patient's measurement period is defined as the number of days between the Index Prescription Start Date and the end of the Report Period. When calculating the number of days the patient was covered by at least one drug in the class, if prescriptions for the same drug overlap, the prescription start date for the second prescription will be adjusted to be the day after the previous fill has ended.

Note: If a medication was started and then discontinued, CRS will recalculate the number of Days Prescribed by subtracting the prescription date (i.e., visit date) from the V Medication Discontinued Date. For example:

- Rx Date: November 15, 2016
- Discontinued Date: November 19, 2016

Recalculated number of Days Prescribed:
November 19, 2016 – November 15, 2016 = 4

Example of Proportion of Days Covered

Report Period: January 1 through December 31, 2016

- First prescription:
 - Index Rx Start Date: March 1, 2016
 - Days' Supply: 90
 - Prescription covers patient through May 29, 2016
- Second prescription:
 - Rx Date: May 26, 2016
 - Days' Supply: 90
 - Prescription covers patient through August 27, 2016
- Third prescription:
 - Rx Date: September 11, 2016
 - Days' Supply: 180
 - Gap:

September 11, 2016 – August 27, 2016 = 15 days

- Prescription covers patient through March 8, 2017

Patient's measurement period:

March 1, 2016 through December 31, 2016 = 306 days

Days patient was covered:

*March 1, 2016 through August 27, 2016 +
September 11, 2016 through December 31, 2016 = 292 days*

PDC:

$292 \div 306 = 95\%$

Each Gap Numerator

CRS will calculate whether a gap in medication therapy of 30 or more days has occurred between each consecutive medication dispensing event during the Report Period. A gap is calculated as the days not covered by the days' supply between consecutive medication fills.

Example of Medication Gap greater than or equal to 30 Days:

Report Period: January 1 through December 31, 2016

- First prescription:
 - Rx Date: April 1, 2016
 - Days' Supply: 30
 - Prescription covers patient through April 30, 2016
- Second prescription:
 - Rx Date: July 1, 2016
 - Days' Supply: 90
 - Gap #1:
 - July 1, 2016 – April 30, 2016 = 61 days*

Prescription covers patient through September 28, 2016

- Third prescription:
 - Rx Date: October 1, 2016
 - Days' Supply: 90
 - Gap #2:
 - October 1, 2016 – September 28, 2016 = 2 days*
- Prescription covers patient through December 29, 2016

Gap #1 \geq 30 days

Patient will be included in the numerator for that medication.

2.9.4.6 Patient List

List of patients 18 and older prescribed medication therapy medication with proportion of days covered and gap days.

2.9.5 Primary Medication Non-adherence

2.9.5.1 Owner and Contact

Chris Lamer, PharmD

2.9.5.2 National Reporting

Not reported nationally

2.9.5.3 Denominators

1. Number of e-prescriptions for newly initiated drug therapy for chronic medications for Active Clinical patients ages 18 and older.

2.9.5.4 Numerators

1. Number of medications returned to stock within 30 days.

2.9.5.5 Definitions

Denominator Inclusion

To be included in the denominator, the e-prescription must be for a chronic medication during the Report Period.

Denominator Exclusions

- Any prescription where there is a prescription dispensing record in the preceding 180 days for the same drug.
- Any duplicate medications, defined as any medication that has been e-prescribed twice in a 30-day period with no prescription fill in between the e-prescriptions.
- Any prescription sent to an outside pharmacy, as it is not possible to know if the medication was returned to stock.

Chronic Medications

Defined by the following taxonomies: BGP PQA ASTHMA INHALED STEROIDS, BGP PQA COPD, BGP PQA DIABETES ALL CLASS, BGP PQA RASA MEDS, BGP PQA STATIN MEDS

Numerator Inclusion

To be included in the numerator, the e-prescription medication must have a comment of RETURNED TO STOCK within 30 days of the prescription date (i.e., visit date).

2.9.5.6 Patient List

List of patients 18 and older with an e-prescription for chronic medications, with returned to stock, if any.

2.9.6 Medications Education**2.9.6.1 Owner and Contact**

Patient Education Program: Chris Lamer, PharmD

2.9.6.2 National Reporting

Not reported nationally

2.9.6.3 Denominators

1. Active Clinical patients with medications dispensed at their facility during the Report Period.
2. User Population patients with medications dispensed at their facility during the Report Period.

2.9.6.4 Numerators

1. Patients who were provided patient education about their medications in any location.

2.9.6.5 Definitions**Patients receiving medications**

Are identified any entry in the VMed file for your facility.

Medication Education

Any Patient Education code containing “M-” or “-M” or Patient Education codes DMC-IN, FP-DPO, FP-OC, *-NEB, *-MDI, or FP-TD.

2.9.6.6 Patient List

List of patients receiving medications with med education, if any

2.9.7 Medication Therapy Management Services**2.9.7.1 Owner and Contact**

Chris Lamer, PharmD

2.9.7.2 National Reporting

Not reported nationally

2.9.7.3 Denominators

1. Active Clinical patients 18 and older with medications dispensed at their facility during the Report Period.

2.9.7.4 Numerators

1. Patients who received medication therapy management (MTM) during the Report Period.

2.9.7.5 Definitions**Patients receiving medications**

Are identified any entry in the VMed file for your facility.

Medication Therapy Management

MTM defined as:

- CPT 99605 through 99607
- Clinic codes: D1, D2, D5

2.9.7.6 Patient List

List of patients 18 and older receiving medications with medication therapy management, if any.

2.9.8 Public Health Nursing

2.9.8.1 Owner and Contact

Tina Tah, RN, BSN, MBA

2.9.8.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; not reported to OMB and Congress)

2.9.8.3 Denominators

1. User Population patients.

2.9.8.4 Numerators

1. For User Population only, the number of patients in the denominator served by PHNs in any setting, including Home.
2. For User Population only, the number of patients in the denominator served by a PHN driver/interpreter in any setting
3. For User Population only, the number of patients in the denominator served by PHNs in a HOME setting.
4. For User Population only, the number of patients in the denominator served by a PHN driver/interpreter in a HOME setting.
5. Count only (no percentage comparison to denominator). Number of visits to User Population patients by PHNs in any setting, including Home
 - A. Number of visits to patients age 0 through 28 days (Neonate)
 - B. Number of visits to patients age 29 days to 12 months (Infants)
 - C. Number of visits to patients ages 1 through 64 years
 - D. Number of visits to patients ages 65 and older (Elders)
 - E. Number of PHN driver/interpreter (Provider code 91) visits.
6. Count only (no percentage comparison to denominator). Number of visits to User Population patients by PHNs in Home setting. Broken down into age groups: 0 through 28 days (neonate), 29 days through 12 months (infants), 1 through 64 years, 65 and older (elders).
 - A. Number of Home visits to patients age 0 through 28 days (Neonate)

- B. Number of Home visits to patients age 29 days to 12 months (Infants)
- C. Number of Home visits to patients ages 1 through 64 years
- D. Number of Home visits to patients ages 65 and older (Elders)
- E. Number of PHN driver/interpreter (Provider code 91) visits

2.9.8.5 Definitions

PHN Visit-Any Setting

Any visit with Primary or Secondary Provider codes 13 or 91.

PHN Visit-Home

Any visit with one of the following:

- Clinic code 11 and a primary or secondary provider code of 13 or 91
- Location Home (as defined in Site Parameters) and a Primary or Secondary Provider code 13 or 91

2.9.8.6 Patient List

List of patients with PHN visits documented.

Numerator codes in patient list:

- All PHN equals Number of PHN visits in any setting
- Home equals Number of PHN visits in home setting
- Driver All equals Number of PHN driver/interpreter visits in any setting
- Driver Home equals Number of PHN driver/interpreter visits in home setting

2.9.9 Breastfeeding Rates

Note: This measure is used to support the reduction of the incidence of childhood obesity.

2.9.9.1 Owner and Contact

Tina Tah, RN, BSN, MBA

2.9.9.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; not reported to OMB and Congress)

2.9.9.3 Denominators

1. Active Clinical patients who are 30 through 394 days old.
2. GPRA: Active Clinical patients who are 30 through 394 days old who were screened for infant feeding choice at the age of 2 months (45 through 89 days).
3. Active Clinical patients who are 30 through 394 days old who were screened for infant feeding choice at the age of 6 months (165 through 209 days).
4. Active Clinical patients who are 30 through 394 days old who were screened for infant feeding choice at the age of 9 months (255 through 299 days).
5. Active Clinical patients who are 30 through 394 days old who were screened for infant feeding choice at the age of 1 year (350 through 394 days)
6. User Population patients who are 30 through 394 days old who were screened for infant feeding choice at the age of 2 months (45 through 89 days).

2.9.9.4 Numerators

1. Patients who were screened for infant feeding choice at least once.
2. Patients who were screened for infant feeding choice at the age of 2 months (45 through 89 days).
3. Patients were screened for infant feeding choice at the age of 6 months (165 through 209 days).
4. Patients who were screened for infant feeding choice at the age of 9 months (255 through 299 days).
5. Patients who were screened for infant feeding choice at the age of 1 year (350 through 394 days).
6. GPRA: Patients who, at the age of 2 months (45 through 89 days), were either exclusively or mostly breastfed.
7. Patients who, at the age of 6 months (165 through 209 days), were either exclusively or mostly breastfed.
8. Patients who, at the age of 9 months (255 through 299 days), were either exclusively or mostly breastfed.
9. Patients who, at the age of 1 year (350 through 394 days), were either exclusively or mostly breastfed.

2.9.9.5 Definitions

Patient Age

Since the age of the patient is calculated at the beginning of the Report Period, this measure may include patients up to 25 months old if they were within the eligible age range on the first day of the Report Period, and will not include any patients that were born after the first day of the Report Period. Patients born after the first day of the Report Period will be included in the following Report Period.

Infant Feeding Choice

The documented feeding choice from the file V Infant Feeding Choice that is closest to the exact age that is being assessed will be used. For example, if a patient was assessed at 45 days old as half breastfed and half formula fed and assessed again at 65 days old as mostly breastfed, the mostly breastfed value will be used since it is closer to the exact age of 2 months (i.e., 60 days). Another example is a patient who was assessed at 67 days as mostly breastfed and again at 80 days as mostly formula. In this case, the 67 days value of mostly breastfed will be used. The other exact ages are 180 days for 6 months, 270 days for 9 months, and 365 days for 1 year.

In order to be included in the age-specific screening numerators, the patient must have been screened at the specific age range. For example, if a patient was screened at 6 months and was exclusively breastfeeding but was not screened at 2 months, then the patient will only be counted in the 6 months numerator.

2.9.9.6 GPRA 2016 Description

During GPRA Year 2016, achieve the target rate of 35.8% for the proportion of 2-month olds who are mostly or exclusively breastfeeding.

2.9.9.7 Patient List

List of patients 30 through 394 days old, with infant feeding choice value, if any.

2.9.10 Use of High Risk Medications in the Elderly

2.9.10.1 Owner and Contact

Dr. Bruce Finke

2.9.10.2 National Reporting

Not reported nationally

2.9.10.3 Denominators

1. Active Clinical patients ages 65 and older. Broken down by gender and age groups: 65 through 74 years, 75 through 84 years, and 85 years and older.

2.9.10.4 Numerators

1. Patients who received at least one high risk medication for the elderly during the Report Period.
2. Patients who received at least two different high risk medications for the elderly during the Report Period.

2.9.10.5 Definitions

Note: The logic below is a deviation from the logic written by PQA, as PQA requires at least two prescriptions fills for the same high-risk medication during the Report Period, while the logic below only requires one prescription fill.

- For nitrofurantoin, a patient must have received a cumulative days' supply for any nitrofurantoin product greater than 90 days during the Report Period.
- For nonbenzodiazepine hypnotics (BGP HEDIS NONBENZODIAZ MEDS), a patient must have received a cumulative days' supply for any nonbenzodiazepine hypnotic products greater than 90 days during the Report Period.

High Risk Medications for the Elderly

Defined with medication taxonomies:

- BGP HEDIS ANTICHOLINERGIC MEDS
 - First-generation antihistamines (Includes combination drugs) (Brompheniramine, Carbinoxamine, Chlorpheniramine, Clemastine, Cyproheptadine, Dexbrompheniramine, Dexchlorpheniramine, Diphenhydramine (oral), Doxylamine, Hydroxyzine, Promethazine, Triprolidine); Antiparkinson agents (Benztropine (oral), Trihexyphenidyl)
- BGP HEDIS ANTITHROMBOTIC MEDS
 - (Ticlopidine, Dipyridamole, oral short-acting)
- BGP HEDIS ANTI-INFECTIVE MEDS
 - (Nitrofurantoin)
- BGP HEDIS CARDIOVASCULAR MEDS

- Alpha blockers, central (Guanfacine, Methyldopa, Reserpine); Cardiovascular, other (Disopyramide, Digoxin, Nifedipine, immediate release)
- BGP HEDIS CENTRAL NERVOUS MEDS
 - Tertiary TCAs (Includes combination drugs) (Amitriptyline, Clomipramine, Doxepin, Imipramine, Trimipramine); Antipsychotics, first-generation (conventional) (Thioridazine); Barbiturates (Amobarbital, Butabarbital, Butalbital, Pentobarbital, Phenobarbital, Secobarbital); Central Nervous System, other (Chloral hydrate, Meprobamate); Nonbenzodiazepine hypnotics (Eszopiclone, Zolpidem, Zaleplon); Vasodilators (Ergoloid mesylates, Isoxsuprine)
- BGP HEDIS ENDOCRINE MEDS
 - Endocrine (Desiccated thyroid, Estrogens with or without progesterone (oral and topical patch products only), Megestrol); Sulfonylureas, long-duration (Chlorpropamide, Glyburide)
- BGP HEDIS GASTROINTESTINAL MED
 - (Trimethobenzamide)
- BGP HEDIS PAIN MEDS
 - Other (Meperidine, Pentazocine); Non-COX-selective NSAIDs (Indomethacin, Ketorolac)
- BGP HEDIS SKL MUSCLE RELAX MED
 - (Includes combination drugs) (Carisoprodol, Chlorzoxazone, Cyclobenzaprine, Metaxalone, Methocarbamol, Orphenadrine)

Note: For each medication, the days' supply must be > 0. If a medication was started and then discontinued, CRS will recalculate the number of Days Prescribed by subtracting the prescription date (i.e., visit date) from the V Medication Discontinued Date. For example:

- Rx Date: November 15, 2016
- Discontinued Date: November 19, 2016

Recalculated number of Days Prescribed:
November 19, 2016 – November 15, 2016 = 4

Medications must not have a comment of RETURNED TO STOCK.

2.9.10.6 Patient List

List of patients 65 and older with at least one prescription for a potentially harmful drug.

2.9.11 Use of Benzodiazepine Sedative Hypnotic Medications in the Elderly

2.9.11.1 Owner and Contact

Chris Lamer, PharmD

2.9.11.2 National Reporting

Not reported nationally

2.9.11.3 Denominators

1. Active Clinical patients ages 65 and older.
2. User Population patients ages 65 and older.

2.9.11.4 Numerators

1. Patients who received at least two prescription fills for any benzodiazepine sedative hypnotic medications for more than 90 days.

2.9.11.5 Definitions

- The patient must have received a cumulative days supply for any benzodiazepine sedative hypnotic products greater than 90 days during the Report Period.
- Benzodiazepine sedative hypnotic medications defined with medication taxonomy BGP PQA BENZODIAZ MEDS. (Medications are: Estazolam, Flurazepam, Quazepam, Temazepam, Triazolam)

Note: For each medication, the days' supply must be > 0. If a medication was started and then discontinued, CRS will recalculate the number of Days Prescribed by subtracting the prescription date (i.e., visit date) from the V Medication Discontinued Date. For example:

- Rx Date: November 15, 2016

- Discontinued Date: November 19, 2016

Recalculated number of Days Prescribed:

November 19, 2016 – November 15, 2016 = 4

Medications must not have a comment of RETURNED TO STOCK.

2.9.11.6 Patient List

List of patients 65 and older with two or more prescriptions for benzodiazepine sedative hypnotic medications.

2.9.12 Functional Status in Elders

2.9.12.1 Owner and Contact

Dr. Bruce Finke

2.9.12.2 National Reporting

Not reported nationally

2.9.12.3 Denominators

1. Active Clinical patients ages 55 and older. Broken down by gender.

2.9.12.4 Numerators

1. Patients screened for functional status at any time during the Report Period.

2.9.12.5 Definitions

Functional Status

Any non-null values in V Elder Care for the following:

- At least one of the following ADL fields: toileting, bathing, dressing, transfers, feeding, or continence
- At least one of the following IADL fields: finances, cooking, shopping, housework/chores, medications or transportation during the Report Period.

2.9.12.6 Patient List

List of patients 55 and older with functional status codes, if any.

The following abbreviations are used in the Numerator column:

- **TLT.** Toileting
- **BATH.** Bathing
- **DRES.** Dressing
- **XFER.** Transfers
- **FEED.** Feeding

- **CONT.** Contenance
- **FIN.** Finances
- **COOK.** Cooking
- **SHOP.** Shopping
- **HSWK.** Housework/Chores
- **MEDS.** Medications
- **TRNS.** Transportation

2.9.13 Fall Risk Assessment in Elders

2.9.13.1 Owner and Contact

Dr. Bruce Finke

2.9.13.2 National Reporting

Not reported nationally

2.9.13.3 Denominators

1. Active Clinical patients ages 65 and older. Broken down by gender.

2.9.13.4 Numerators

1. Patients who have been screened for fall risk or with a fall-related diagnosis in the past year.

Note: This numerator does *not* include refusals.

- A. Patients who have been screened for fall risk in the past year.
 - B. Patients with a documented history of falling in the past year.
 - C. Patients with a fall-related injury diagnosis in the past year.
 - D. Patients with abnormality of gait/balance or mobility diagnosis in the past year.
2. Patients with a documented refusal of fall risk screening exam in the past year.

2.9.13.5 Definitions

Fall Risk Screen

Any of the following:

- Fall Risk Exam defined as: Exam code 37
- CPT 1100F, 1101F, 3288F
- History of Falling defined as: POV ICD-9: V15.88 (Personal History of Fall); ICD-10: Z91.81
- Fall-related Injury Diagnosis defined as: POV ICD-9: (Cause codes #1 through 3) E880.*, E881.*, E883.*, E884.*, E885.*, E886.*, E888.*; ICD-10: (All codes ending in A or D only) W01.*, W06.* through W08.*, W10.*, W18.*, W19.*
- Abnormality of Gait/Balance or Mobility defined as: POV ICD-9: 781.2, 781.3, 719.7, 719.70 (old code), 719.75 through 719.77 (old codes), 438.84, 333.99, 443.9; ICD-10: G25.7*, G25.89, G25.9, G26, I69.*93, I73.9, R26.*, R27.*

Refusal

Refusal of Exam 37

2.9.13.6 Patient List

List of patients 65 years and older with fall risk assessment, if any.

2.9.14 Palliative Care

2.9.14.1 Owner and Contact

Dr. Bruce Finke

2.9.14.2 National Reporting

Not reported nationally

2.9.14.3 Denominators

1. No denominator, count only.

2.9.14.4 Numerators

1. Count only (no percentage comparison to denominator). For patients meeting the Active Clinical definition, the total number of patients with at least one palliative

care visit during the Report Period; broken down by age groups: younger than 18 years, 18 through 54 years, 55 years and older.

2. Count only (no percentage comparison to denominator). For patients meeting the Active Clinical definition, the total number of palliative care visits during the Report Period; broken down by age groups: younger than 18 years, 18 through 54 years, 55 years and older.

2.9.14.5 Definitions

Palliative Care Visit

POV ICD-9: V66.7; ICD-10: Z51.5

2.9.14.6 Patient List

List of patients with a palliative care visit, if any.

2.9.15 Annual Wellness Visit

2.9.15.1 Owner and Contact

Dr. Bruce Finke

2.9.15.2 National Reporting

Not reported nationally

2.9.15.3 Denominators

1. Active Clinical patients ages 65 and older. Broken down by gender.

2.9.15.4 Numerators

1. Patients with at least one Annual Wellness Exam in the past 15 months.

2.9.15.5 Definitions

Annual Wellness Exam

CPT G0438, G0439, G0402

2.9.15.6 Patient List

List of patients with an annual wellness visit in the past 15 months.

2.9.16 Optometry

2.9.16.1 Owner: Contact

Dr. Dawn Clary

2.9.16.2 National Reporting

NATIONAL (included in IHS Performance Report; *not* reported to OMB and Congress)

2.9.16.3 Denominators

1. GPRA Developmental (NQF 0086): Active Clinical patients ages 18 and older with a diagnosis of primary open-angle glaucoma during the Report Period.

2.9.16.4 Numerators

1. GPRA Developmental (NQF 0086): Patients with an optic nerve head evaluation during the Report Period.

2.9.16.5 Definitions

Primary open-angle glaucoma

- POV ICD-9: 365.10-365.12, 365.15; ICD-10: H40.10* - H40.12*, H40.15*

Optic nerve head evaluation

- CPT: 2027F

2.9.16.6 Patient List

List of patients 18 and older with primary open-angle glaucoma and optic nerve head evaluation, if any.

2.9.17 Goal Setting

2.9.17.1 Owner and Contact

Patient Education: Chris Lamer, PharmD

2.9.17.2 National Reporting

Not reported nationally

2.9.17.3 Denominators

1. User Population patients.
2. Number of goal topics set during the Report Period.
3. Number of goal topics met during the Report Period.

2.9.17.4 Numerators

1. Number of patients who set at least one goal during the Report Period.
2. Number of goals set for ALCOHOL OR OTHER DRUGS.
3. Number of goals set for DIABETES CURRICULUM.
4. Number of goals set for MEDICATIONS.
5. Number of goals set for MONITORING.
6. Number of goals set for NUTRITION.
7. Number of goals set for OTHER.
8. Number of goals set for PHYSICAL ACTIVITY.
9. Number of goals set for STRESS AND COPING.
10. Number of goals set for TOBACCO.
11. Number of goals set for WELLNESS AND SAFETY.
12. Number of patients who met at least one goal during the Report Period.
13. Number of goals met for ALCOHOL OR OTHER DRUGS.
14. Number of goals met for DIABETES CURRICULUM.
15. Number of goals met for MEDICATIONS.
16. Number of goals met for MONITORING.
17. Number of goals met for NUTRITION.
18. Number of goals met for OTHER.
19. Number of goals met for PHYSICAL ACTIVITY.
20. Number of goals met for STRESS AND COPING.

21. Number of goals met for TOBACCO.

22. Number of goals met for WELLNESS AND SAFETY.

2.9.17.5 Definition

Patient Goal Numerator Logic

Goal Set

The Goal Setting value must be "Goal Set" and the Goal Start Date must be during the Report Period.

Goal Met

The Goal Status value must be "Goal Met" and the Date/Time Last Modified must be during the Report Period. The patient is not required to have set a goal during the Report Period.

2.9.17.6 Patient List

List of User Population patients with goal setting information during the Report Period

List of Acronyms

Acronym	Term Meaning
ABG	Arterial Blood Gas
ACEI	Angiotensin Converting Enzyme Inhibitors
ADR	Adverse Drug Reactions
AI/AN	American Indian/Alaska Native
AMA	Against Medical Advice
AMI	Acute Myocardial Infarction
APT	Acute Phase Treatment
ARB	Angiotensin Receptor Blocker
ART	Patient Allergies File
ASA	Aspirin (acetylsalicylic acid)
ASBI	Alcohol Screening and Brief Intervention
BH	Behavioral Health
BHS	Behavioral Health System
BMI	Body Mass Index
BNI	Brief Negotiated Interview
BP	Blood Pressure
CABG	Coronary Artery Bypass Graft
CBC	Complete Blood Count
CCB	Calcium Channel Blocker
CHD	Coronary Heart Disease
CHR	Community Health Representative
CK	Creatine Kinase
CONPT	Continuation Phase Treatment
COPD	Chronic Obstructive Pulmonary Disease
CPT	Current Procedural Terminology
CVX	Vaccine Code
CRS	Clinical Reporting System
DM	Diabetes Mellitus
DNKA	Did Not Keep Appointment
DPST	Demo/Test Patient Search Template
ER	Emergency Room
ESRD	End Stage Renal Disease
ETDRS	Early Treatment Diabetic Retinopathy Study
ETS	Environmental Tobacco Smoke

Acronym	Term Meaning
FAS	Fetal Alcohol Syndrome
FIT	Fecal Immunochemical Test
FOBT	Fecal Occult Blood Test
FY	Fiscal Year
GFR	Glomerular Filtration Rate
GPRA	Government Performance and Results Act of 1993
HIV	Human Immunodeficiency Virus
ICD	International Classification of Diseases
IFC	Infant Feeding Choice
IHS	Indian Health Service
IMM	Immunization
IPV/DV	Intimate Partner Violence/Domestic Violence
IVD	Ischemic Vascular Disease
LABA	Long-Acting Beta2 Agonist
LDL	Low-density Lipoprotein
LOINC	Logical Observations Identifiers, Names, Codes
LVAD	Left Ventricular Assistive Device
LVS	Left Ventricular Systolic
MAOI	Monoamine Oxidase Inhibitors
MTM	Medication Therapy Management
NMI	Not Medically Indicated
OA	Osteoarthritis
OMB	Office of Management and Budget
OPC	Optimal Practitioner Contact
PCC	Patient Care Component
PCI	Percutaneous Coronary Interventions
PDC	Proportion of Days Covered
PEPC	Patient and Family Education Protocols and Codes
POV	Purpose of Visit
PRC	Purchased and Referred Care
RA	Rheumatoid Arthritis
RAS	Renin Angiotensin System
RCIS	Referred Care Information System
RPMS	Resource and Patient Management System
SNRI	Serotonin-Norepinephrine Reuptake Inhibitors
SSRI	Selective Serotonin Reuptake Inhibitors
STI	Sexually Transmitted Infection

Acronym	Term Meaning
TCA	Tricyclic Antidepressants
TIA	Transient Ischemic Attack
ULN	Upper Limit of Normal
URI	Upper Respiratory Infection

Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

Phone: (888) 830-7280 (toll free)

Web: <http://www.ihs.gov/helpdesk/>

E-mail: support@ihs.gov